



SYNERGY
CHIROPRACTIC & PHYSIOTHERAPY

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PHYSICIAN REFERRAL
for
PLEASE EVALUATE AND TREAT WITH

CHIROPRACTIC, ACUPUNCTURE and PHYSIOTHERAPY

PATIENT NAME: _____

PATIENT D.O.B: _____ **PATIENT PHONE:** _____

DIAGNOSIS/Description: _____

Please check all that apply;

- Chiropractic
- Physiotherapy
- Acupuncture

PRECAUTIONS/SPECIAL INSTRUCTIONS: _____

PHYSICIAN'S SIGNATURE: _____ **DATE:** _____

PHYSICIAN'S NAME: _____