**ALIGN WELLNESS LAB**
PHYSICIAN REFERRAL PAD
1039 GABLES DR. UNIT 103,
FOREST, VA 24551

## REFERRING PROVIDER INFORMATION

Provider Name: _____ Practice Name: _____
NPI: _____ Phone: _____
Fax: _____Email: _____

## PATIENT INFORMATION

Patient Name: _____
DOB: _____ Phone: _____

## CLINICAL GOALS / INDICATIONS

□ Post-surgical recovery
□ Soft tissue injury
□ Chronic pain / inflammation
□ Neurological recovery
□ Sports performance / recovery
□ Wound healing support
□ Myofascial restriction / muscle tension
□ Metabolic health / nutritional optimization
□ Recovery optimization
□ Other: _____

## REFERRAL SERVICES (CHECK ALL THAT APPLY)

□ Hyperbaric Oxygen Therapy (HBOT)
□ Red Light Therapy
□ NormaTec Compression
□ Massage Therapy
□ Nutrition Analysis / Counseling
□ Supplementation

## CLINICAL NOTES / SPECIAL INSTRUCTIONS

_____
_____

## FREQUENCY / DURATION

□ Evaluate and treat □ _____ sessions per week for _____ weeks

□ Other: _____

## SIGNATURE

Provider Signature: _____ Date: _____