SIMPLY RESULTS

YOUR BEST MOVES, PUT TOGETHER, FOR GOOD.

REFERRAL: Tell us about the patient you're sending, and the reason(s) why.

Patient Name:	
DOB:	
Email:	
Phone:	
Address:	
Diagnosis (tell us why):	
ICD-10 (if known):	

Add your own name, credentials, and contact information. Sign and date.

Provider Name:		Provider Title:
Email:		Phone:
Fax:		Address:
SIGNATURE:		DATE:

Use a HIPAA-compliant method to let us know ASAP that this person needs us:

By Mail: Simply Results Physical Therapy • 9 Williamsburg Lane • Chico, CA 95926

By Fax: 530-345-3375. Or, use your own form. Include records to inform our care.

Please give a copy of the completed referral to **both** the patient **and** us. Questions? 530-891-4456.