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Referral

Patient______________________________ **Date**________________

Diagnosis	**ICD-10**
☐ **Neck Pain**	**M54.2**
☐ **Cervical Radiculopathy**	**M54.12**
☐ **Shoulder Pain**	**M25.519**
☐ **Elbow Pain**	**M25.52**
☐ **Wrist Pain**	**M25.539**
☐ **Low Back Pain**	**M54.5**
☐ **Lumbar Radiculopathy**	**M54.16**
☐ **SI Joint Pain**	**M53.3**
☐ **Hip Pain**	**M25.559**
☐ **Knee Pain**	**M25.569**
☐ **Foot Pain**	**M25.57**
☐ **Balance**	**R26.81**

Other/SpecificTreatment

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Frequency/Duration ____

Physician Signature____