

Mettler Therapy
2906 Crossing Ct
Champaign IL, 61822
Ph. (217) 398-9800
Fx. (217) 366-0037
mettlercenter.com

Mettler Therapy Patient Referral

Mettler Institute
30 N LaSalle St, Suite 3430
Chicago, IL 60602
Ph. (312) 269-0099
Fx. (312) 269-0033
mettlerinstitute.com

Patient: Last: _____ First: _____ DOB: ____/____/____ Today's Date: ____/____/____

Diagnosis: _____ Primary ICD10: _____ Notes: _____

Diagnosis: _____ Primary ICD10: _____ Notes: _____

Treatment Recommendations: Evaluate and Treat

- | | | | | |
|---|---|--|---|--------------------------------------|
| <input type="checkbox"/> Manual Therapy | <input type="checkbox"/> Therapeutic Exercise | <input type="checkbox"/> Sports Rehab | <input type="checkbox"/> Electrical Stim. | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> ASTYM® Treatment | <input type="checkbox"/> Neuromuscular Re-education | <input type="checkbox"/> Iontophoresis | <input type="checkbox"/> Desensitization | _____ |
| <input type="checkbox"/> Trigger Point Dry Needling | <input type="checkbox"/> ADL (Activities of Daily Living) | <input type="checkbox"/> Ultrasound | <input type="checkbox"/> Ice/Heat | _____ |
| <input type="checkbox"/> Therapeutic Activities | <input type="checkbox"/> Home Exercise Program | <input type="checkbox"/> Gait Training | <input type="checkbox"/> TENS | _____ |

Precautions: _____

Comments: _____

Frequency & Duration: _____ times per week for _____ weeks or _____ visits.

Physician's Signature: _____ Name Printed: _____

Physician Phone: (_____) _____ - _____ Physician Fax: (_____) _____ - _____

Thank you for your referral.