DMR clinics
Referral Form

Hopkins Health & Wellness
Phone: 952-933-5085
Fax: 952-931-2159
PT@HopkinsWellness.com
15 8th Avenue North
Hopkins, MN 55343

Name: _____ Date of Birth: _____

Diagnosis: _____ Dx Codes: _____

Onset/DOI: _____ Insurance: _____ Phone Number: _____

☐ Evaluate & Treat Frequency: _____/wk Duration: _____ Weeks Total Visits: _____

General Physical Therapy & Sports Rehabilitation

Exercise/Fitness
___ Posture/Body Mechanics
___ Stretching/Flexibility
___ Passive ROM
___ Active/Assistive ROM
___ Balance/Stability Training
___ Proprioceptive Exercise Training
___ Core Strengthening
___ Stabilization/Strengthening
___ Home Exercise Program
___ Progressive Fitness
___ Return to Sports Rehab
_____

Manual Therapy
___ Dynamic Muscle Technique (DMT)
___ Active Release Therapy (ART)
___ Craniosacral Therapy
___ Myofacial Release
___ Deep Tissue Release
___ Trigger Point Release
___ Motion Assisted Muscle Release
___ Soft Tissue Mobilization
___ Integrated Progressive Mobilization (IPM)
___ Spinal Manipulative Therapy

Modalities, Braces & Supplies
___ Cold Laser
___ Traction ☐ Cervical ☐ Lumbar
___ Ultrasound
___ Interferential E Stim
___ Game Ready
___ Kinesiotaping
___ Brace/Support: _____
___ Tens Unit
___ Orthotics
___ Home Traction ☐ Cerv ☐ Lumb

Other: _____

DMR Method

☐ **DMR Method Evaluate and Treat**

☐ **Lumbar** ☐ **Cervical** ☐ **Other:** _____

☐ Acute ☐ Chronic

☐ Limited (6-12 visits) strain/sprains, non-radicular pain, minor sports injuries

☐ Progressed (12-20 visits) facet syndrome, headaches, sciatica, cervicobrachial syndrome

☐ Advanced (20-24 visits) disc herniation, DDD, spondylolisthesis, stenosis, post-operative

Special instructions: _____

Other Services

☐ **Chiropractic Integrated Progressive Mobilization (IPM)**

☐ **Massage Therapy**
☐ Deep Tissue ☐ Sports ☐ Myofacial ☐ Craniosacral

☐ **Dry Needling**
Area:

This form is a Prescription and a Statement of Medical Necessity and is valid with any licensed physical therapist in Minnesota.

Physician Name: _____

Signature: _____ Date: _____

Clinic: _____ Fax: _____