ORTHO LAZER
Orthopedic Laser Center

Referral Date _____ Surgery Date (if applicable) _____

PATIENT INFORMATION

Name _____ DOB _____

Phone _____

Address _____ Email _____

REFERRAL FOR

Diagnosis _____

Area(s) to Treat

Special Postop Instructions (Brace, wrap, dressing, wound care)

Number Of Treatments

☐ Acute (6) ☐ Chronic (12) ☐ Postop (6)

Relative Contraindications? ☐ None ☐ Yes, but approved to treat

List Contraindications

SPECIAL INSTRUCTIONS

☐ Anterior ☐ Other ☐ Additional Considerations

☐ Posterior

☐ Medial

☐ Lateral

☐ Nerve Tracing

Provider Name _____

First Visit Date _____ Time _____

05242023