

## Physician Referral

HealthQuest's Doctors of Chiropractic value the relationships that have already been created with local physicians of all disciplines. Doctor's of Chiropractic recognize the importance of multi-disciplinary team management for improved clinical outcomes. Our goal is to work collaboratively and develop a mutually beneficial relationship that ultimately provides the patient with the best care possible.

We use a comprehensive federally certified electronic record keeping system that allows us to provide documentation in a timely fashion to the referring physician. We strive for open communication and are happy to discuss the benefits of chiropractic management. We also recognize when further referral is necessary.

Please call our office at 207.778.5123 and set up a time to visit our facility. You will find that the HealthQuest staff is professional, competent and a pleasure to work with for the benefit of your patients and your practice. Please click [here](#) for our referral form and fax it to 207.778.5125,

**HealthQuest Chiropractic**  
383 Wilton Road  
Farmington, ME 04938  
207-778-5123

### ***Rx for Chiropractic Care: Physician Referral***

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_  
Patient's condition/diagnosis: \_\_\_\_\_

- |   |   |
|---|---|
| <input type="checkbox"/> Mechanical lower back pain   | <input type="checkbox"/> Extremity Pain           |
| <input type="checkbox"/> Sprain/strain injury (C-T-L) | <input type="checkbox"/> Thoracic Pain            |
| <input type="checkbox"/> Myofascial pain              | <input type="checkbox"/> Thoracic Outlet Syndrome |
| <input type="checkbox"/> Facet Joint Dysfunction      | <input type="checkbox"/> Fibromyalgia             |
| <input type="checkbox"/> SI Joint Dysfunction         | <input type="checkbox"/> Carpal Tunnel Syndrome   |
| <input type="checkbox"/> Disc Injury/Bulge/HNP        | <input type="checkbox"/> TMJ                      |
| <input type="checkbox"/> Sciatic Neuritis             | <input type="checkbox"/> Chronic Pain Syndrome    |
| <input type="checkbox"/> Neck Pain/ Whiplash          | <input type="checkbox"/> Other: _____             |

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Please provide the following service(s):

- Evaluate and treat X-ray
- Consult/Second Opinion Only
- Number of visits requested or date range: \_\_\_\_\_.
- Spinal Manipulation
- Myofascial Release
- Soft tissue/trigger point therapy
- Physical therapy modalities
- Rehabilitation / Supervised Exercise
- Other \_\_\_\_\_

Referring Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Provider's Name: \_\_\_\_\_

**Fax to HealthQuest Chiropractic at 207-778-5125**