MID-ATLANTIC
SPINAL REHAB & CHIROPRACTIC

REFERRAL WITH WORKING DIAGNOSIS

Name: _____ **Date:** _____

Date of Birth: _____

Type of Injury: (circle one) Motor Vehicle Collision | Pedestrian | Slip & Fall | Bus Accident | Worker's Comp

Date of Injury: _____

PRESENTING AREA(S) OF CHIEF COMPLAINT (CIRCLE ALL APPLICABLE):

AXIAL SPINE	UPPER EXTREMITY		LOWER EXTREMITY		THORAX	NON MSK
Headaches	Shoulder	L | R | Bi	Hip	L | R | Bi	Chest	Nausea
Neck	Upper Arm	L | R | Bi	Thigh	L | R | Bi	Abdomen	Vomiting
Upper Back	Elbow	L | R | Bi	Knee	L | R | Bi	Ribs (L | R | Bi)	Tinnitus
Mid Back	Forearm	L | R | Bi	Lower Leg	L | R | Bi	Clavicle (L | R | Bi)	Memory Loss
Low Back	Wrist	L | R | Bi	Ankle	L | R | Bi		Blurred Vision
Pelvis/ SI Joint (L | R | Bi)	Hand	L | R | Bi	Foot	L | R | Bi		Dizziness
TMJ (L | R | Bi)	Finger	L | R | Bi	Toe	L | R | Bi		Other: _____

WORKING DIAGNOSIS (CIRCLE ALL APPLICABLE):

AXIAL SPINE	UPPER EXTREMITY		LOWER EXTREMITY		THORAX		NON MSK
Muscle Spasm	Shoulder Sprain/Strain	L | R | Bi	Hip Sprain/Strain	L | R | Bi	Chest	Lac | Cont Abrasion	Concussion
Post-Traumatic Headache	Elbow Sprain/Strain	L | R | Bi	Knee Sprain/Strain	L | R | Bi	Abdomen	Lac | Cont Abrasion	
Cervical Sprain/Strain	Wrist Sprain/ Strain	L | R | Bi	Ankle Sprain/ Strain	L | R | Bi	Rib (L | R | Bi)	Lac | Cont Abrasion	
Thoracic Sprain/Strain	Hand Sprain/Strain	L | R | Bi	Foot Sprain/Strain	L | R | Bi	Clavicle (L | R | Bi)	Lac | Cont Abrasion	
Lumbosacral Sprain/Strain	Finger Sprain/Strain	L | R | Bi	Toe Sprain/Strain	L | R | Bi	Other: _____		
Sacroiliac Joint Sprain/Strain	Other: _____	L | R | Bi	Other: _____	L | R | Bi			
TMJ Sprain/Strain							

Proposed Treatment Plan:

The patient will begin care at 5x | 4x | 3x | 2x | 1x per WEEK | MONTH for 6 | 5 | 4 | 3 | 2 | 1 week(s) and re-evaluation will be performed. Care will include physiotherapeutic modalities and chiropractic spinal manipulation as appropriate.

Reason for Medical Referral:

- ☐ Patient has acute musculoskeletal pain. Please medically co-manage and give us a second opinion and future treatment recommendations.
- ☐ Please consider appropriateness of advanced imaging (MRI/CT/Nerve Studies) of the _____ region.
- ☐ Please review advanced imaging (MRI/CT/Nerve Studies) and make future treatment recommendations.
- ☐ Please evaluate and treat for concussion/mild traumatic brain injury.

Signature: _____

MID-ATLANTIC
SPINAL REHAB & CHIROPRACTIC

OUR PROVIDERS

Dr. Marc Gulitz, D.C.
Dr. Erica Wise, D.C.
Dr. Anna Welty, D.C.
Dr. Zach Woods, D.C.
Dr. Noelle Miller, D.C.
Dr. Joshua Levin, D.C.
Dr. Kaykavoos Kashi, D.C.
Dr. Tricia Muneses, D.C.
Dr. Xavier Touze, D.C.

LOCATIONS

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6810 Park Heights Ave., Suite C4
Baltimore, MD 21215

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4600 Wilkens Ave., Suite 102
Baltimore, MD 21229

NORTHEAST BALTIMORE
9430 Harford Road Office #1
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DOWNTOWN BALTIMORE
2001 Eastern Ave., 1st Floor
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