



INTEGRA
Rehabilitation Physicians

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www.IntegraRehabPhysicians.com

Patient Name: _____ Parent/Guardian: _____

DOB: _____ Phone #: _____ Alternate Phone #: _____

Insurance Carrier: _____ Insurance ID #: _____

Reason for Referral: _____

Diagnosis/ICD10: _____

PHYSICIAN SERVICES: (Please send H&P and recent clinic visit note with initial referral)

- | | |
|--|---|
| <input type="checkbox"/> Brain Injury/Post-Concussive Symptoms | <input type="checkbox"/> Pain Management |
| <input type="checkbox"/> Cancer Rehabilitation | <input type="checkbox"/> Pediatrics |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Prosthetics/Orthotics |
| <input type="checkbox"/> Joint/Trigger Point Injection | <input type="checkbox"/> Spasticity Management/Botox Injections |
| <input type="checkbox"/> Lymphedema | <input type="checkbox"/> Spinal Cord Injury |
| <input type="checkbox"/> Musculoskeletal Evaluation | <input type="checkbox"/> Sports Medicine |
| | <input type="checkbox"/> Stroke rehabilitation |
| | <input type="checkbox"/> Other: _____ |

Practice: _____ **Contact Person:** _____

Fax #: _____ **Telephone #:** _____

Print MD Name: _____ **NPI:** _____

MD Signature: _____ **Date:** _____