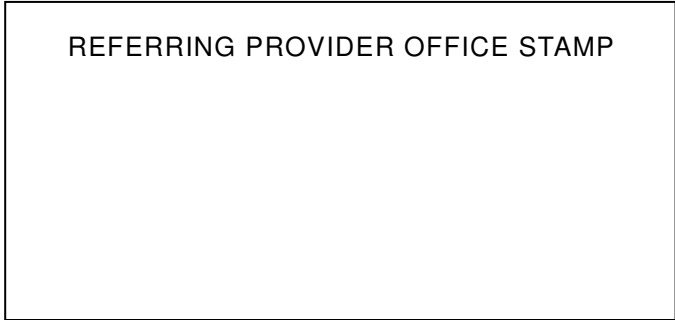




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* PLEASE ATTACH PATIENT DEMOGRAPHICS *

PATIENT NAME _____ PHONE NUMBER _____

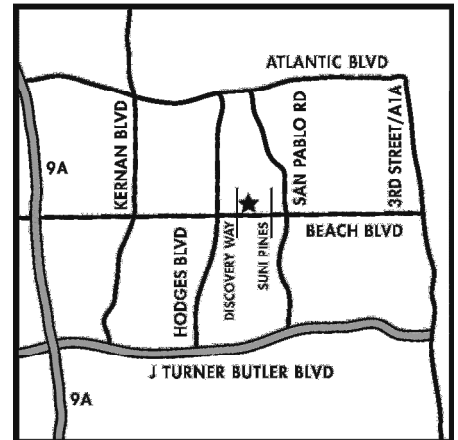
Diagnosis _____ ICD9 _____

Special Instructions/Precautions _____

- _____ Physical therapy evaluation and treatment as indicated
- _____ Occupational therapy evaluation and treatment as indicated

PROGRAMS

- | | |
|--|--|
| <input type="checkbox"/> General Orthopedic Rehabilitation | <input type="checkbox"/> Spinal Stabilization |
| <input type="checkbox"/> Balance/Vestibular Rehabilitation | <input type="checkbox"/> Fall Prevention |
| <input type="checkbox"/> Oncology Rehabilitation | <input type="checkbox"/> Medical/Surgical Rehabilitation |
| <input type="checkbox"/> Pediatric Rehabilitation | <input type="checkbox"/> Performing Arts Rehabilitation |
| <input type="checkbox"/> Foot/Ankle Rehabilitation | <input type="checkbox"/> Geriatric Rehabilitation |
| <input type="checkbox"/> Arthritis Care/Management | <input type="checkbox"/> Neurological Rehabilitation |
| <input type="checkbox"/> Sports Performance Training | <input type="checkbox"/> Fibromyalgia Rehabilitation |
| <input type="checkbox"/> General Conditioning and Wellness | <input type="checkbox"/> Home Program Design |
| <input type="checkbox"/> Lymphedema Therapy | <input type="checkbox"/> |



In my professional opinion, based on the above medical practice standards, the above-named patient requires rehabilitation services for the problems identified. I hereby request that the professional staff evaluate and assess the patient's needs for such services and provide me with a detailed patient plan of care for my approval.

Physician Name _____

Physician Signature _____ Date _____