_ Evaluate/Treat Physical Therapy

Date:____

Patient Name: ________________________________

Phone: _____________________________________

Diagnosis: ___________________________________

Precautions: _________________________________

Type of Surgery : ______________________________

Frequency & Duration of Treatment: ________________________

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Treat only as specified below:

Additional Comments: ____

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This prescription is an order to evaluate and treat unless specified otherwise above.

I CERTIFY THAT THE ABOVE TREATMENT PLAN IS MEDICALLY NECESSARY AND IS APPROVED.

Physician Signature _______________________________________ Date __________________________

Print Physician Name ______________________________________NPI Number____________________

This must be signed by Doctor in order for you to receive treatment