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Patient Name: _____ Patient Phone #: _____

Reason for Referral: _____

Referring Physician: _____

Evaluate & Treat

Continue Plan of Care

Goals:

Special Programs:

- Improve Range of Motion
- Improve Strength
- Improve Balance
- Improve Gait Skills
- Improve ADLs
- Improve Functional Mobility
- Decrease Pain
- Other: _____

- Vestibular/Balance Rehab
- Joint Replacement Rehab
- Cardiac Physical Therapy
- Pulmonary Physical Therapy
- Stroke/Neuro Rehab
- Shoulder Rehab
- Neck/Back Pain
- Strength and Conditioning

Frequency/Duration: 1x, 2x, 3x, 4x, 5x per week for _____ weeks.

Comments: _____

I Certify that physical therapy is medically necessary.

Physicians's Signature

Date