

Date: _____

Patient _____ Phone: _____

Diagnosis: _____

Procedures: Patient To Be Seen _____ Times A Week For: _____ Weeks _____

Evaluate And Treat: _____ Functional Capacity Evaluation: _____

Spine: _____ Work Conditioning/Hardening: _____

Shoulder: _____ Return to Work Evaluation: _____

Elbow and Hand: _____ Impairment Rating: _____

SI and Hip: _____ Pregnancy Program: _____

Knee: _____

Ankle and Foot: _____

I certify the prescribed treatment above is medically necessary .

Physician: _____

Patient's next scheduled doctor's appointment: _____

Donna S. Morgan, R.N.
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