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Patient Name: ____Patient Phone #: ___________________

Reason for Referral: ____

Referring Physician: ____

❑ **Evaluate & Treat**

❑ Continue Plan of Care

Goals:

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

Special Programs:

- ❑ 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:____

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I Certify that physical therapy is medically necessary.

____ ______________

Physicians's Signature Date

100% Veteran Owned