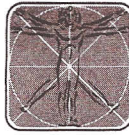


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Patient Name _____ **Date** _____

Patient Telephone Number _____

Diagnosis _____ **ICD9** _____

Special Instructions/Precautions _____

Weight Bearing Status: FWB PWB NWB Right Left

_____ **Physical Therapy Evaluation and Treatment as Indicated**

_____ **Occupational Therapy Evaluation and Treatment as Indicated**

PROGRAMS

- _____ General Orthopedic Rehabilitation
- _____ Balance/Vestibular Training
- _____ Oncology Rehabilitation
- _____ Pediatric Rehabilitation
- _____ Foot/Ankle Rehabilitation
- _____ Arthritis Care/Management
- _____ Sports Performance Training
- _____ General Conditioning and Wellness

- _____ Spinal Stabilization
- _____ Fall Prevention
- _____ Medical/Surgical Rehabilitation
- _____ Performing Arts Rehabilitation
- _____ Geriatric Rehabilitation
- _____ Neurological Rehabilitation
- _____ Fibromyalgia Rehabilitation
- _____ Home Program Design

In my opinion, in accordance with accepted 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 _____ **M.D.**

Physician Signature _____ **M.D. Date** _____