Central Scheduling

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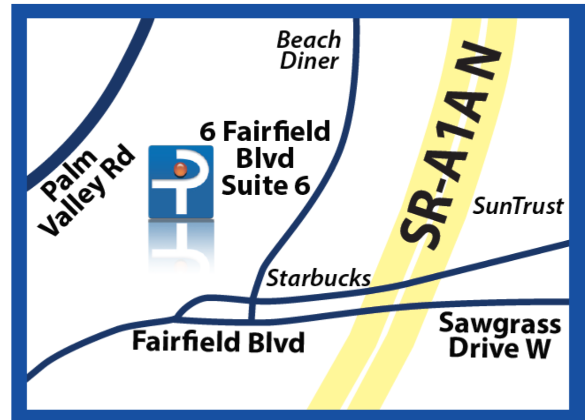

PATIENT NAME: _______________________________________ DOB: ______________

PHONE NUMBER: ______________________________________

DIAGNOSIS: ____

SPECIAL INSTRUCTIONS/ PRECAUTIONS: ____________________________________
____

☐ Physical Therapy evaluation and treatment as medically necessary

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 treat the patient's needs for such services and provide me with a detailed patient plan of care for my approval.

Physician Name: _______________________________________

Physician Signature: ____________________________________ Date: _______________