PREMIER PHYSICAL THERAPY

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Central Scheduling

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32224

Ponte Vedra Beach

6 Fairfield Blvd.
Ponte Vedra Beach, FL
32082

Avenues

11339 Distribution Ave E.
Jacksonville, FL
32256

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: _____