

Physical Therapy Prescription

Please fax to 330-915-3876 and bring to your first appointment

To make an appointment please call: 440-462-9370

Patient Information:

Name: _____ DOB: _____

Home/Cell Phone: _____

Insurance: _____

Requested Physical Therapy

- Physical Therapy Evaluation and Treatment
- Specialty Rehab Programs:
 - Running Program
- Other: _____

Diagnosis: _____

Frequency: _____ times per week

Duration: _____ weeks

Specific Instructions or Precautions:

Surgery Date (please attach protocol if applicable): _____

Physician Information:

I certify that physical therapy is medically necessary for the patient's plan of care

Physician Signature: _____

Date: _____

Office Phone: _____