Name: ______________________________ **Date:** ______________

Patient Phone # ______________________________ **DOB:** ______________

Diagnosis: ____

Area To Be Treated: ____

PHYSICAL THERAPY - Evaluate and Treat

Special Instructions / Precautions: ______________________________

____

____

Print Provider's Name: ____

Office Phone # ____

Referring Provider Signature:

____

I hereby certify that the services indicated
above are medically necessary

Phone: (706) 868-1707 • Fax: (706) 868-1351 • www.erwpt.com

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