ERW PHYSICAL THERAPY

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

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