

Physical Therapy / Occupational Therapy REFERRAL

Patient Name: _____

Reason for Referral: _____

Special Programs & Services:

___ Evaluation & Treatment

___ Therapeutic Exercise

___ Massage Therapy

___ Manual Therapy

___ Total Knee Replacement Protocol

___ Rotator Cuff Repair Protocol

___ _____

___ One Time Evaluation & Home Exercise Program

___ Onsite Home Safety Assessment

___ Worksite Ergonomic Assessment

I CERTIFY THAT THESE SERVICES ARE MEDICALLY NECESSARY.

Physician Signature:

Date:

Referring Physician Name (PRINTED)

Treatment Locations:

Onsite - In your patient's home, office, or other location

Middletown Clinic - 5900 Long Meadow Dr, Middletown, OH 45005

Monroe Clinic - 20 Overbrook Dr Ste D, Monroe, OH 45050

Physical Therapy Referral Pad Template

Annelies Wilder-Smith

A red circular graphic with a gradient, appearing as a partial circle or a thick arc, located to the right of the author's name.

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