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Call (888) 786-2888
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Patient Information & Rx to:
Fax (866) 295-3343

SB 899 Allows 24 PT Visits For Acute Injuries

Patient Name: _____ DOB: ____ / ____ / ____ Date: ____ / ____ / ____

Patient Phone: _____ Date of Injury: ____ / ____ / ____

Diagnosis: _____ Freq/Duration: _____

Treatment Plan

- | | |
|---|---|
| <input type="checkbox"/> Evaluate | <input type="checkbox"/> Work Conditioning |
| <input type="checkbox"/> Back Program | <input type="checkbox"/> Pool/Aquatic Therapy |
| <input type="checkbox"/> Shoulder Program | <input type="checkbox"/> Occupational Therapy |
| <input type="checkbox"/> Cervical Program | <input type="checkbox"/> Acupuncture |
| <input type="checkbox"/> Knee Program | <input type="checkbox"/> Certified Hand Therapy |
| <input type="checkbox"/> Ankle Program | <input type="checkbox"/> Hand Program |

Procedures

- | | |
|---|---|
| <input type="checkbox"/> Modalities | <input type="checkbox"/> Therapeutic Exercise |
| <input type="checkbox"/> Electrical | <input type="checkbox"/> Stabilization |
| <input type="checkbox"/> Traction | <input type="checkbox"/> Mobilization |
| <input type="checkbox"/> Iontophoresis | <input type="checkbox"/> Myo-Facial Release |
| <input type="checkbox"/> Home Ther Exer | <input type="checkbox"/> General Conditioning |

Additional Recommendations

Doctor: _____

Doctor P.H.#: _____

Signature: _____

(Stamp or Handwritten Endorsement)

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