Rehab Professionals of Cleveland, Inc.

Physical Therapy

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Patient Name: _____

Medical Diagnosis: _____

Treatment Precautions/Contraindications: _____

Surgical Procedure Date: _____

☐ Evaluate and Treat

☐ Please Evaluate and Treat with the Following Recommendations:

☐ Stretching	☐ Strengthening	☐ Balance Training
☐ Therapeutic Exercise	☐ Dynamic Trunk Stabilization	☐ Soft Tissue Stretching
☐ Gait Training	☐ Aquatic Exercise	☐ Electrical Stimulation
☐ Manual Therapy	☐ Joint Mobilization	☐ Iontophoresis
☐ Ultrasound	☐ _____	

Frequency and Duration ☐ Therapist's Discretion

☐ _____ Times a Week x _____ Weeks

Please Send Reports ☐ via: fax (_____) _____ - _____

☐ email: _____

☐ mail:

_____ _____

Physician's Signature Date

This referral serves as a letter of medical necessity for these services.

www.rehabpros.net

For Map and Locations See Reverse