

SOUTHWEST ORTHOPEDIC ASSOCIATES PHYSICAL THERAPY

PHONE: 817-731-9400 FAX ORDER TO: 817-984-8578

Please attach patient insurance and demographics.

- ☐ **4441 Bryant Irvin N.**
Fort Worth , TX 76107

Date : _____

Patient Name: _____

Diagnosis: _____

Frequency of Treatment
1 2 3 4 5 visits/per week

Duration of Treatment
1 2 3 4 5 weeks

-
- ☐ **Evaluate and Treat**
- ☐ **Other:** _____
- ☐ **Modalities:** _____
- ☐ **Special Instructions:** _____
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I certify that this patient is under my care. The rehab services prescribed above are medically necessary and in accordance to a plan established and reviewed by licensed physical therapists.

Printed Physician's Name: _____

Referring Physician's Signature: _____