PT on the PLAINS

Patrick Allen, DPT, certDN

Patient Name: _____ **Phone:** _____

Physician: _____ **Follow Up Appt:** _____

Diagnosis: _____ **ICD-10:** _____

Surgery: _____ **Surgery Date:** _____

Evaluate and Treat

Precautions / Special Instructions / Contraindications

Frequency / Duration_____times per week for_____weeks.

I hereby certify these services as medically necessary for this patient's plan of care.

Physician Signature: _____ Date: _____

1888 Ogletree Road, Suite 190 • Auburn,AL 36830
Phone: 334-209-0445 • Fax: 334-209-0507
www.physicaltherapyontheplains.com