

PT on the PLAINS

Patrick Allen, DPT, certDN

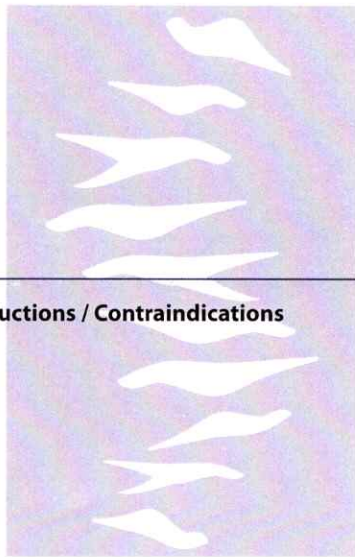
Patient Name: _____ Phone: _____

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