MORELLA PHYSICAL THERAPY CLINIC

Established 1985

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DATE ______________________

PATIENT NAME ____

DIAGNOSIS ____

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TREATMENTS PER WEEK ____________________ for ____________________ weeks

☐ **EVALUATE AND TREAT AS PHYSICAL THERAPIST DEEMS APPROPRIATE**

TREATMENT REQUESTS: ____

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PRECAUTIONS: ____

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FOR INSURANCE PURPOSES, THIS DOCUMENT SHALL SERVE AS A STATEMENT OF MEDICAL NECESSITY FOR PHYSICAL THERAPY RENDERED TO THE ABOVE REFERENCED PATIENT.

PHYSICIANS SIGNATURE ____