HEATHER BAZINET PHYSICAL THERAPY

Name ________________________________ Date ________________

Date of Injury / Surgery ____

Diagnosis / ICD-10 Codes ____

____

☐ Evaluate and Treat

Instructions & Precautions

____

____

____

Frequency & Duration _____ / week for _____ weeks or ____ visits

All of the above is medically necessary based upon history, physical examination, diagnostic tests, and clinical severity and requires medically supervised treatment.

X Doctor's Signature ______________________________________

Phone _________________________ Fax _________________________

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