RETURN TO HEALTH

Date: ______________________

Patient Name: ____ DOB: _____________________________

Cell Phone: _______________________________ Home Phone: ___________________________________

Diagnosis Codes: ____

Referring Physician: ____

Attorney/Insurance Information: __________________________/__________________________________

___ EVALUATE AND TREAT

THERAPY:

____ PHYSICAL THERAPY
____ AQUATIC THERAPY
____ WORK HARDENING/CONDITIONING PROGRAMS
____ EXTRACORPOREAL SHOCKWAVE THERAPY (ESWT)

DIAGNOSTIC STUDIES:

____ PPT (Physical Performance Test)
____ FCE (Functional Capacity Evaluation)

___ IMPAIRMENT RATING

___ CUSTOM ORTHOTIC SHOE INSERTS

___SHOETHOTICS

Shoe Plus Custom Orthotic

Comments/Precautions:

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____
____

I have examined the patient and have determined that outpatient rehabilitation is medically necessary.

Physician Signature: ____ Date: _____________________

Return to Health, LLC
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