Andrew Garrett, D.C.
Clinic Director

Robert Spicer, M.D.
Medical Director

Morenike Badmus, D.P.T.

Date: _________________

Patient Name: ____ DOB: ________________________

Cell Phone: _________________________________ Home Phone: __________________________________

Diagnosis Codes: ____

Referring Physician: ____

Attorney/Insurance Information: ___________________________/_________________________________

THERAPY: **____ Evaluate and Treat**

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

DIAGNOSTIC STUDIES:

____ PPT
____ FCE
____ EMG/NCV

PAIN MANAGEMENT/INJECTIONS:

____ Cervical Pain	____Thoracic Pain	____Lumbar Pain		
Upper Extremity:	____Shoulder R/L	____Elbow R/L	____Wrist R/L	____Hand R/L
Lower Extremity:	____Hip R/L	____Knee R/L	____Ankle R/L	____Foot R/L

____ **IMPAIRMENT RATING**

____ **CUSTOM ORTHOTIC SHOE INSERTS**

Comments/Precautions:

____
____
____

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

Physician Signature: ____ Date: ____________________

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