



RETURN TO HEALTH

Andrew Garrett, D.C.
Clinic Director

Robert Spicer, M.D.
Medical Director

Date: _____

Patient Name: _____ DOB: _____

Cell #: _____ Home #: _____

Diagnosis Codes: _____

Referring Physician: _____

Attny Info/Ins Info: _____ / _____

THERAPY:

_____ Evaluate and Treat

- _____ PHYSIOTHERAPY
- _____ AQUATIC THERAPY
- _____ WORK HARDENING/CONDITIONING PROGRAMS
- _____ MASSAGE

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 | |

Comments/Precautions:

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

Physician Signature: _____ Date: _____

Return to Health, LLC
 4474 Spring Valley Rd
 Farmers Branch, TX 75244
 (P): (469) 677-0076
 (F): (469) 677-0195