



PT CONSULTATION

PHYSICAL THERAPY

developmentdesigndirection

\* Please provide patient demographics when faxing script.

PATIENT NAME

PATIENT PHONE NUMBER: (HOME)

(WORK)

DIAGNOSIS

ICD-10

EVALUATION ONLY

EVALUATE AND TREAT

FREQUENCY

times per week

DURATION

weeks

PRECAUTIONS AND SPECIAL INSTRUCTIONS

ALTER G® Anti Gravity Treadmill



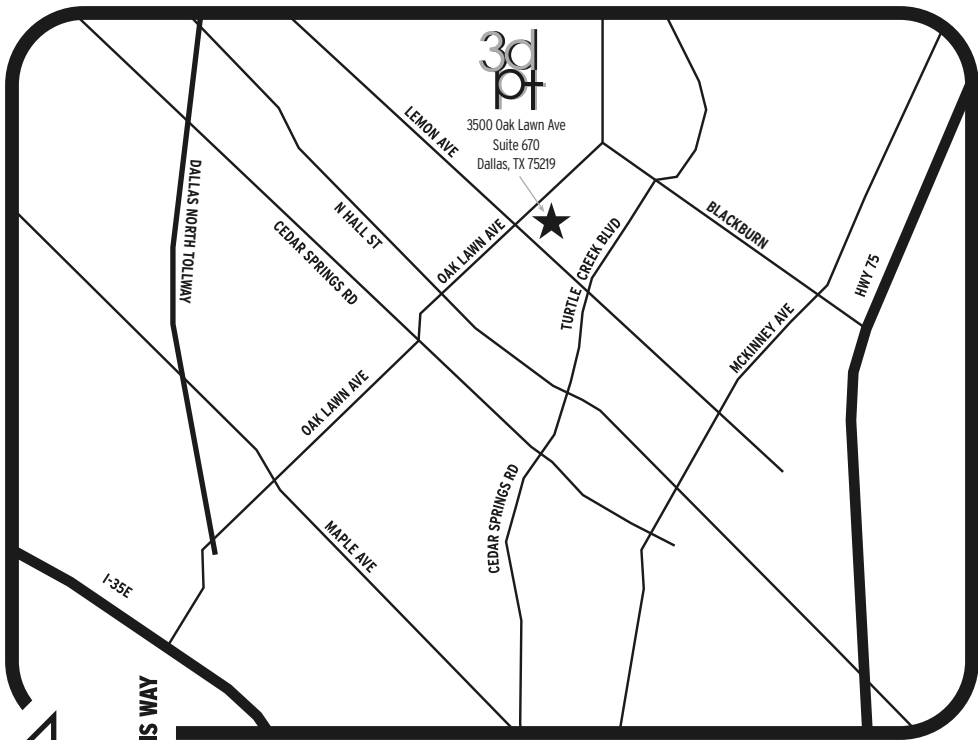
REFERRING PROVIDER NAME(PRINTED)

REFERRING PROVIDER SIGNATURE

DATE

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phone 469.372.0021 :: fax 469.372.0029



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