Dr. Sarah Eads *PT, DPT, CSCS* **Dr. Linda Wells** *PT, DPT*

PHYSICAL THERAPY REFERRAL

Referral Date: ____________________

Patient Name: __________________________ Patient Phone: ____________________ DOB: ______________

Diagnosis: ____ Date of Surgery: ____________________________

☐ Evaluate and Treat as Indicated

☐ Specific Prescription: ____

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LETTER OF MEDICAL NECESSITY:

The above rehabilitation services are required for the normal course of patient rehabilitation for the above diagnosis. The services requested are to protect the injury and/or surgical repair. This will allow the patient to resume the normal activities of rehabilitation. Without the use of these services the patient will be at risk for extended rehabilitation and additional therapeutic costs.

Physician Name: ____

Physician Signature: ____

210-526-2428 | 210-817-8684

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