EXERCISABILITIES
PHYSICAL THERAPY • MEDICAL FITNESS
Falls Prevention • Aquatic • Neurologic Recovery

Dear Medical Provider,

Your client, _____, DOB:_____ has requested to be seen in our clinic for _____. If you agree, please complete the attached form and fax back to our clinic. If required by your internal policy, you may return a fax of your own prescription form with the orders for:

_____ Occupational Therapy evaluate and treat

_____ Physical Therapy evaluate and treat

_____ Speech Therapy evaluate and treat

The plan of care will be sent to you after our initial visit for your review and approval signature. Regulations do not require a face to face visit with an approved provider in order to initiate physical therapy, except in case of DME/wheelchair seating requests. Thank you for your assistance in providing great care for this client in a timely manner.

Sincerely,

Exercisabilities, Inc Staff

Fax: 888-624-3107 Phone: 507-259-7570

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email: info@exercisabilitiespt.org

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RX Physical/Speech/Occupational Therapy Prescription

Patient Name:_____ DOB:_____

_____ Occupational Therapy Evaluate and Treat

_____ Physical Therapy Evaluate and Treat

_____ Speech Therapy Evaluate and Treat

Date: _____

Provider Name:_____

Provider Signature:_____

Provider NPI:_____

Provider Return Fax:_____

Provider Phone:_____