EVANS REHABILITATION & WELLNESS

Name _____ Date _____

Patient Phone # _____ DOB _____

Diagnosis _____

Area To Be Treated _____

PHYSICAL THERAPY - Evaluate and Treat

Special Instructions / Precautions _____

_____

_____

Print Provider's Name _____

Office Phone# _____

Referring Provider Signature:

_____

I hereby certify that the services indicated above are medically necessary

Phone: (706) 868-1707 • Fax: (706) 868-1351• www.evansrehab.com

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South Augusta