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Ph: 480-699-4867 Fax: 480-699-4894

Patient Name: _____

Patient Phone #: _____ Date: _____

Diagnosis: _____

Prescription: _____ Evaluate & Treat for Physical Therapy.

Visit frequency/duration: _____ X per week X _____ weeks.

Specific Orders/Precautions/ Requests if any:

Return visit date to referral source: _____

Signed: _____

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