



HARBOR

PHYSICAL THERAPY

and Sports Medicine

Phone 310.547.1850 ~ Fax 310.547.1972

Patient's Name: _____

Authorization Required

(ICD9 Code) _____ **Diagnosis:** _____

Evaluate & Treat

(To include exercise, modalities and procedures PRN)

Area: Neck _____ Back _____ Shoulder _____ Elbow _____ Hand _____

Hip _____ Knee _____ Ankle _____ OTHER _____

Modalities/Procedures

- | | |
|--|---|
| <input type="checkbox"/> Massage | <input type="checkbox"/> Hot Packs |
| <input type="checkbox"/> Fluorimethane Spray | <input type="checkbox"/> Cold Packs |
| <input type="checkbox"/> Joint Mobilization | <input type="checkbox"/> Ice Massage |
| <input type="checkbox"/> Iontophoresis | <input type="checkbox"/> Ultrasound |
| <input type="checkbox"/> Phonophoresis | <input type="checkbox"/> Traction |
| <input type="checkbox"/> Gait Training | <input type="checkbox"/> Electrical Stimulation |
| <input type="checkbox"/> Therapeutic Exercise | <input type="checkbox"/> Tens |
| <input type="checkbox"/> Resisted <input type="checkbox"/> Passive | <input type="checkbox"/> Contrast Baths |
| | <input type="checkbox"/> Whirlpool <input type="checkbox"/> Sterile |

Special Instructions:

Treat Daily.

Treat () Time(s) per week for () weeks

Date _____

_____ M.D.

Physician's Signature

For Worker's Compensation Patients, please complete the following information:

Employer: _____

Comp. Carrier: _____

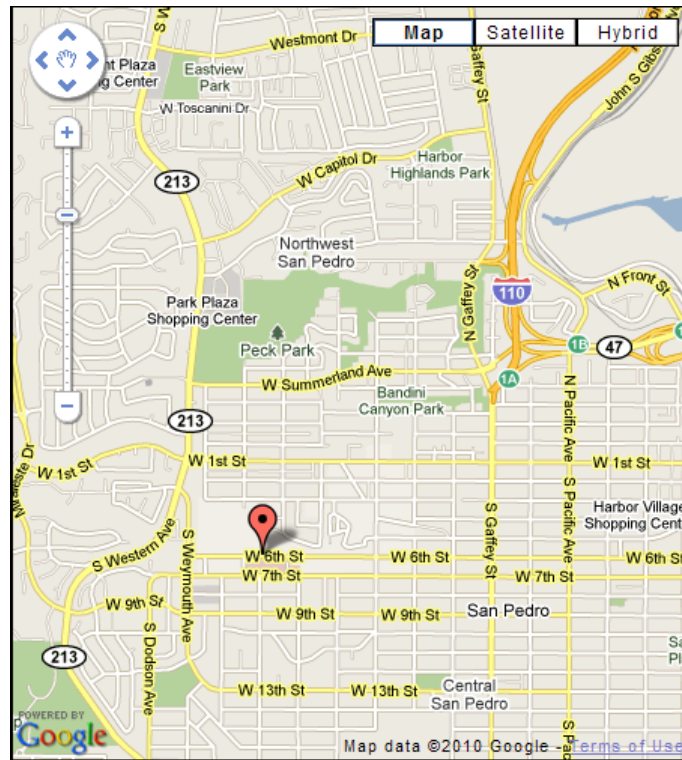
Address: _____

Phone: _____

Claim Number: _____

Adjuster: _____

Date of Injury: _____



1294 West Sixth Street, Suite 101