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

☐ Massage
☐ Fluorimethane Spray
☐ Joint Mobilization
☐ Iontophoresis
☐ Phonophoresis
☐ Gait Training
☐ Theraputic Exercise
☐ Resisted ☐ Passive

☐ Hot Packs
☐ Cold Packs
☐ Ice Massage
☐ Ultrasound
☐ Traction
☐ Electrical Stimulation
☐ Tens
☐ Contrast Baths
☐ Whirlpool ☐ 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: _____

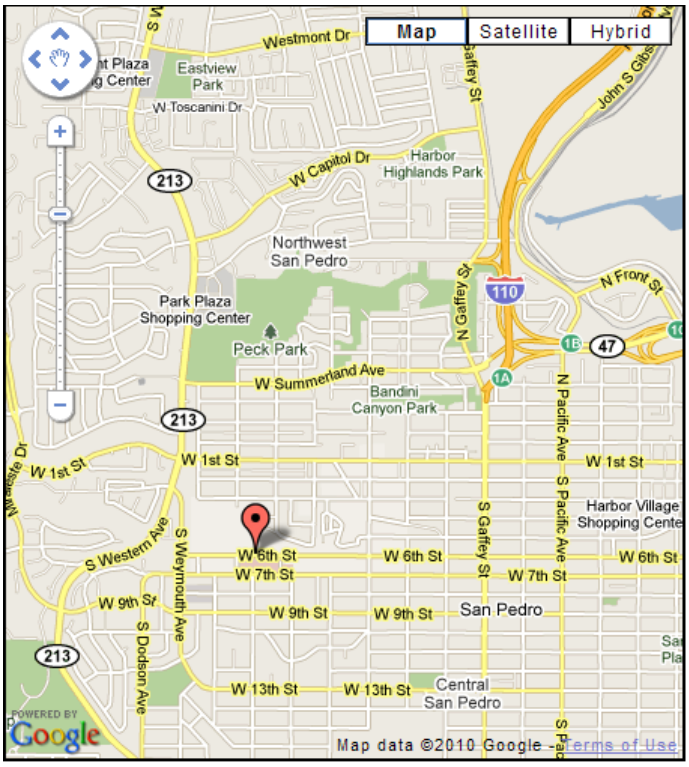
Address: _____

Phone: _____

Claim Number: _____

Adjuster: _____

Date of Injury: _____



1294 West Sixth Street, Suite 101