



Patient Name: _____ Phone: _____

Diagnosis: _____ ICD10 Code: _____

Special Instructions: _____

- EVALUATE & TREAT**
 FREQUENCY:
 2x/wk
 3x/wk
 4x/wk
 5x/wk
 DURATION:
 3 wks
 4 wks
 5 wks
 6 wks
 7 wks
 8 wks

THERAPEUTIC PROCEDURES

- Therapeutic Exercise
- Therapeutic Activities
- Neuromuscular Re-Ed
- ADL
- Gait Training
- ASTYM
- Myofascial Release/Soft Tissue Mobs
- Joint Mobilization
- Traction: Manual
- Massage
- Complete Decongestive Therapy/MLD

MODALITIES

- TENS
- Electrical Stim/NMES
- Traction: Mechanical
- Paraffin Bath
- Phonophoresis
- Iontophoresis
- Ultrasound

DURABLE MEDICAL EQUIPMENT

- TENS for Home Use
- Traction Unit for Home Use
 - Cervical
 - Lumbar
- Other: _____

This prescription certifies that requested therapy is a medical necessity.

Physician Signature: _____ Date: _____

CANAL WINCHESTER 11945 Lithopolis Road, N.W., Canal Winchester, OH 43110
 T: 614-837-4381 • F: 614-833-4266

GAHANNA 1045 Beecher Crossing North, Suite C, Gahanna, OH 43230
 T: 614-775-9618 • F: 614-775-9633

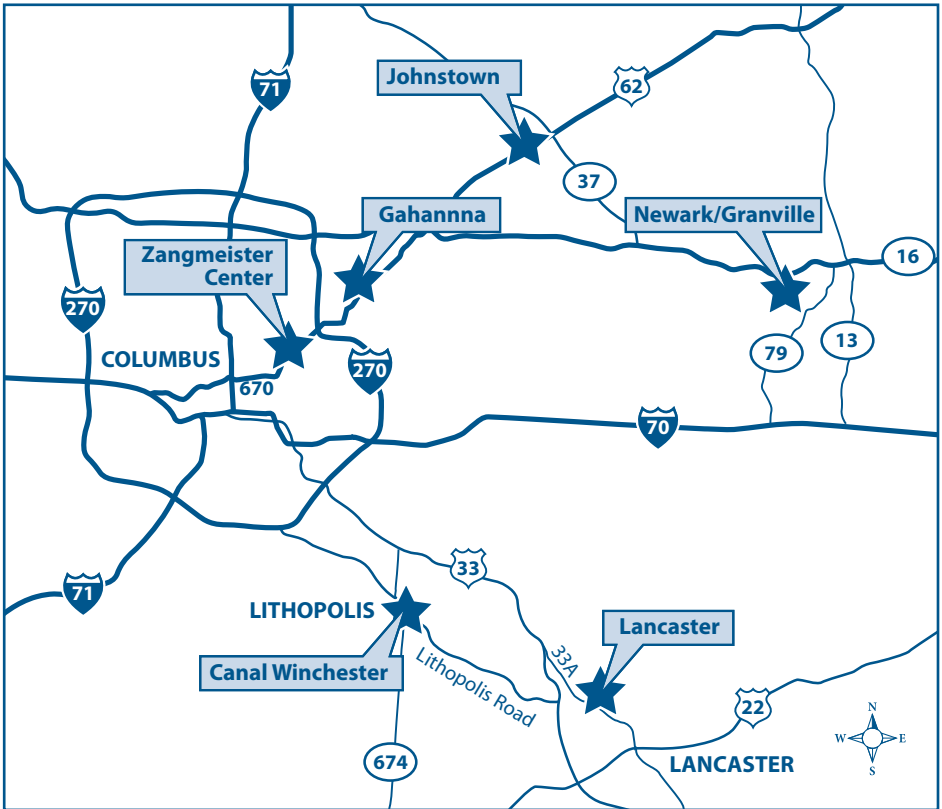
JOHNSTOWN 738 West Coshocton Street, Suite B • Johnstown, OH 43031
 T: 740-200-4221 • F: 740-966-3512

LANCASTER 1506 Hubbard Drive, Lancaster, OH 43130
 T: 740-785-5231 F: 740-785-5489

NEWARK/GRANVILLE 2000 Newark-Granville Road, Suite 203, Granville, OH 43023
 T: 740-788-8100 • F: 740-788-8240

ZANGMEISTER CENTER 3100 Plaza Properties Blvd, Suite 210, Columbus, OH 43219
 T: 614-334-6434 • F: 614-414-6002

DO NOT EMAIL PRESCRIPTION The electronic prescription form is provided for your convenience. With respect to responding to this form, please do not send the prescription via email. Please populate, print and sign a hardcopy that may be faxed, mailed or hand delivered to the clinic. * Workers comp script is valid for 30 days.



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Just a Reminder

Please bring this referral slip with you on your first visit. Please arrive 15 minutes before your scheduled appointment to complete any necessary paperwork.