REHABILITATION SERVICES OF TIFTON, INC.

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THERAPY ORDERS

NAME: _____ DATE: _____

DOB: _____ PATIENT'S PHONE: _____

DIAGNOSIS / CODE: _____

☐ Physical Therapy
☐ Occupational Therapy
☐ Speech Therapy

SPECIAL INSTRUCTIONS / PRECAUTIONS:

TREATMENT PROGRAM:

_____ Evaluate and treat as appropriate

_____ Treatment Instruction (Please specify services in special instructions section)

FREQUENCY of Rx: ____ As needed ____ (x) per week for ____ weeks.

RETURNS TO PHYSICIAN: _____
(Next appointment date)

PHYSICIAN SIGNATURE: _____

PHYSICIAN NAME: _____

PHYSICIAN PHONE: _____