



PHYSICAL
THERAPY

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Alexandria Clinic

Bart Jones, DPT
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Brittica Reed, DPT
Brittany Freeman Fulmer, DPT
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Pineville Clinic

Juliana Meeker, DPT, OCS

Referral for Physical Therapy / Occupational Therapy

Patient Name _____ Date _____

Diagnosis _____

Frequency of Treatment _____ Times a week _____ for weeks

Evaluate and Treat

Special Precautions/Instructions:

The rehabilitation services provided as outlined above are medically necessary and required by the patient.

Signature _____

