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Bruce O'Dell
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Referral

Patient Name _____ Date _____

Diagnosis _____

Special Instructions _____

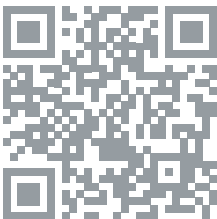
- | | |
|---|--|
| <input type="checkbox"/> Functional Capacity Evaluation | <input type="checkbox"/> Ergonomic Evaluation |
| <input type="checkbox"/> Work Conditioning | <input type="checkbox"/> Post Offer Employment Screen |
| <input type="checkbox"/> Hand Therapy | <input type="checkbox"/> Fit For Duty |
| <input type="checkbox"/> Job Site Evaluation | <input type="checkbox"/> Occupational Therapy Services |

Evaluate and Treat

Other _____

The services provided by IMS as referred are medically necessary and required by the patient.

Physician _____



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our locations.

