|  |  |  |
| --- | --- | --- |
| **4057 Seminole Point Court,** | PREMIERE PILATES  **Rehabilitation & Fitness**  **904-315-0667**  **904-797-8328 (Fax)** | **St Augustine, FL 32086** |

**Physical Therapy Referral /Evaluation/Prescription Form**

Patient’s Name: Date Of Birth:

Primary Insurance: Secondary Insurance:

Insurance ID#: Group #:

Date last seen in office: Diagnoses & Codes:

Referring Provider: Provider NPI #:

Check All That Apply:

Prescription for Physical Therapy Evaluation & Treatment

Prescription for Durable Medical Equipment

**\_\_\_\_\_\_** Medically Necessary\*

Other Information/Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Name (Please Print) Other Authorized Prescriber(Please Print)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Signature Date Signature Date

**By signing as the PCP and/or other authorized provider, I hereby certify that if I am prescribing treatment, I will review each element of the therapy plan of care, that the goals are reasonable and appropriate for this patient, and that if this prescription is for a continuing plan, I have reviewed the patient’s progress and adjusted the plan of care goals if necessary.**