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www.orthosport-therapy.com

Date _____

Patient's Name _____

Date of Birth _____ Phone _____

Diagnosis _____

ICD-9 Codes _____

Requested Treatment _____

Evaluate & Treat

Specific Treatment _____

Frequency: _____ times per week for _____ weeks.

Precautions _____

Provider Re-check Date _____

Provider's signature below constitutes letter of medical necessity.

Referring Provider (Print)

Referring Provider Signature



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LEGEND

- Road/Highways
- Stop Lights/Intersections
- Freeway Off Ramps



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