ELLEN STOLOFF
physical therapy, LLC

THANK YOU FOR YOUR REFERRAL **PLEASE FAX TO 973-533-0295**

PATIENT'S NAME:	SSN#
PATIENT'S ADDRESS:	
PATIENT'S PHONE:	PATIENT'S DOB:
MEDICARE #:	
SECONDARY INSURANCE:	
SECONDARY POLICY #:	

DIAGNOSIS
PT _____ X WEEK FOR _____TOTAL WEEKS

EVALUATE AND TREATMENT AS INDICATED

□ THERAPEUTIC EXERCISE	□ THERAPEUTIC ACTIVITIES TO IMPROVE FUNCTION
□ BALANCE, COORDINATION, PROPRIOCEPTION & POSTURAL TRAINING	□ GAIT TRAINING
□ MANUAL THERAPY	□ ADL TRAINING/SAFETY
□ ORTHOTIC TRAINING	□ PROSTHETIC TRAINING
□ OTHER: _____	

ADDITIONAL NOTES/PRECAUTIONS:_____

I certify these services as medically necessary for the patient's plan of care.

HEALTHCARE PROFESSIONAL NAME:

HEALTHCARE PROFESSIONAL ADDRESS:

HEALTHCARE PROFESSIONAL PHONE:

HEALTHCARE PROFESSIONAL SIGNATURE:

DATE: