Town East
Physical Therapy
& Rehabilitation

TOWN EAST PHYSICAL THERAPY AND REHABILITATION

Date ______________________

Patient's Name ____

Referring Physician ______________________ Physician's Number ______________

Diagnosis ____

☐ Evaluate and Treat ☐ Continue Therapy

Frequency ______________________/wk Duration ______________wks

Instructions/Precautions ____

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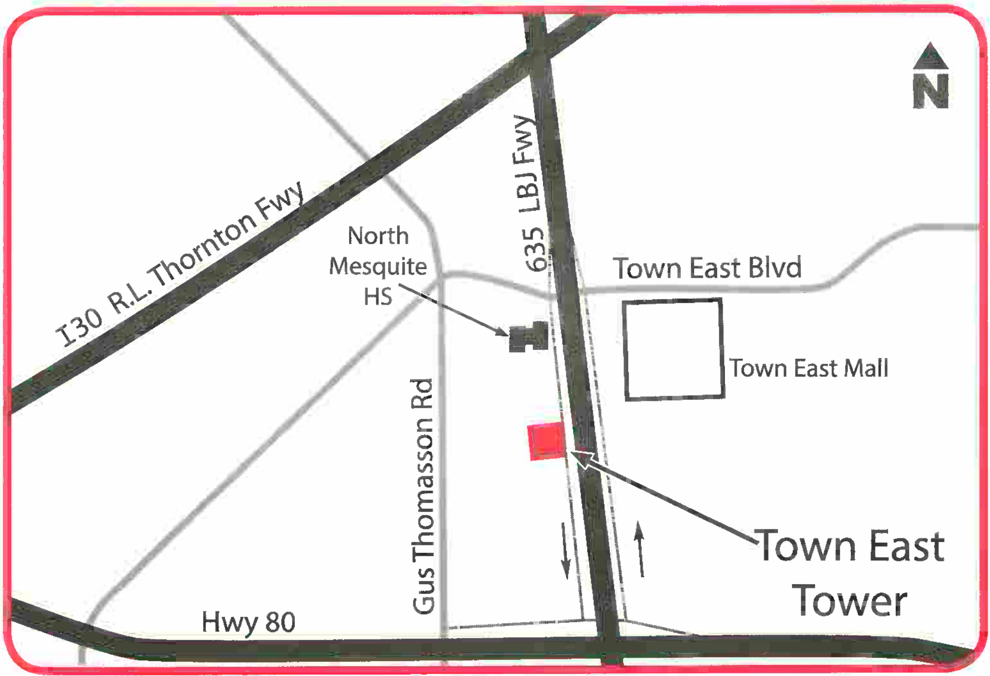
Rehabilitation Services		Testing	Services
☐ Therapeutic Exercise	☐ Work Hardening	☐ Functional Capacity Evaluation	☐ Sports Performance Training
☐ Manual Therapy	☐ Work Conditioning	☐ Physical Performance / Disability Evaluation	☐ Geriatric/Disabled Fitness
☐ Mobilization	☐ Sports Rehabilitation		☐ TENS / NMES
☐ Modalities	☐ Hand Rehabilitation		☐ Personal Fitness Training

Physician's Signature ______________________ Next Appointment ______________



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Town East Tower

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