PHYSICAL THERAPY

Simpson Physical Therapy Center

1525 E. Main • Cushing
(918) 225-2225, ext. 3
Fax (918) 225-4915

Patient Name______________________________

Diagnosis______________________________

Precautions______________________________

1 2 3 4 5 X week for __________ weeks / __________ month (s)

☐ **Evaluate & Treat** ☐ Pool Therapy ☐ Hand Therapy

Comments:______________________________

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

Physician's Signature____________________Date__________

ADMISSION

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