

**SOUTHWEST ORTHOPEDIC ASSOCIATES PHYSICAL THERAPY**

**PHONE: 817-731-9400 FAX ORDER TO: 817-984-8578**

Please attach patient insurance and demographics.

**4441 Bryant Irvin N.** Date : \_\_\_\_\_  
**Fort Worth , TX 76107**

**8465 Boat Club Rd., ste 101**  
**Fort Worth, TX 76179**

**Patient Name:** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_

**Frequency of Treatment**  
**1 2 3 4 5 visits/per week**

**Duration of Treatment**  
**1 2 3 4 5 weeks**

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**Evaluate and Treat**  
 **Other:** \_\_\_\_\_

**Modalities:** \_\_\_\_\_

**Special Instructions:** \_\_\_\_\_

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I certify that this patient is under my care. The rehab services prescribed above are medically necessary and in accordance to a plan established and reviewed by licensed physical therapists.

**Printed Physician's Name:** \_\_\_\_\_

**Referring Physician's Signature:** \_\_\_\_\_