Xcel PHYSICAL THERAPY

PHYSICAL THERAPY PRESCRIPTION

Patient's Name _____ Phone Number _____

Diagnosis _____ ICD10 Code _____

Contraindictions/Weight Bearing Status _____

_____

_____

Frequency/Duration _____ per week x _____weeks

Evaluate and Treat _____

Special Request _____

Comments _____

_____

_____

_____

I certify _____, re-certify _____, that I have examined the patient and physical therapy is medically necessary.

Physician's Signature _____ Date _____

Xcel PHYSICAL THERAPY

ANNA, OH
515 East Main Street, Suite D
Anna, OH 45302
P: 937.639.2063
F: 937.639.2065

BEAVERCREEK, OH
3916 Indian Ripple Rd, Unit 150
Beavercreek, OH 45440
P: 937.702.9735
F: 937.702.9737

FAIRBORN, OH
1164 East Dayton Yellow Springs Road
Fairborn, OH 45324
P: 937.777.3370
F: 937.777.3374

VANDALIA, OH
830 Falls Creek Drive
Vandalia, OH 45377
P: 937.890.9235
F: 937.890.9239