FYZICAL® Therapy & Balance Centers

at Southern Therapy Services, Inc.

CARROLLTON
812 South Park Street
Carrollton, GA 30117
770-834-7436
(FAX) 770-830-5954

VILLA RICA
690 Dallas HWY, STE 203
Villa Rica, GA 30180
770-459-4555
(FAX) 770-459-2550

BREMEN
204 Allen Memorial Dr., STE 301
Bremen, GA 30110
770-537-6477
(FAX) 770-537-0491

Special Instructions:

Retail/Products:

Patient Name: _____ Phone: _____

Referring Physician: _____ Date: _____

Diagnosis: _____

☐ **Evaluate & Treat** ☐ **Continue Current Rx**

Pre/Post-Op Rehabilitation

- ☐ Knee
- ☐ Hip
- ☐ Back
- ☐ Shoulder
- ☐ Neck
- ☐ Elbow
- ☐ Wrist/Hand
- ☐ Ankle/Foot

Balance Rehabilitation

- ☐ Balance Retraining Therapy
- ☐ Falls Risk Assessment
- ☐ Fall Prevention Program
- ☐ Vestibular Rehabilitation
- ☐ Neurological Gait Training

Orthopedic Rehabilitation

- ☐ Strengthening
- ☐ Flexibility/R.O.M.
- ☐ Stabilization
- ☐ Soft Tissue Mobilization
- ☐ Joint Mobilization
- ☐ Other: _____

Programs

- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Hand Therapy
- ☐ Osteoporosis
- ☐ Fibromyalgia
- ☐ Lymphedema
- ☐ Parkinsons
- ☐ Nutrition/Weight Loss
- ☐ Work Hardening
- ☐ Aquatic Therapy
- ☐ Sports Specific
- ☐ TMJ
- ☐ S/P CVA
- ☐ Other

Modalities

- ☐ Ultrasound
- ☐ Electrical Stimulation
- ☐ Iontophoresis
- ☐ Traction
- ☐ Dry Needling
- ☐ IASTM
- ☐ Other: _____

Additional Services

- ☐ Splinting
- ☐ Orthotics
- ☐ Fracture Splints
- ☐ Fitness Exercise
- ☐ Disability Assessment
- ☐ BODY Q
- ☐ Prehab
- ☐ FCA
- ☐ Taping

**All programs include patient education and instructions.*

Frequency: _____ Days per week

Duration: _____ Weeks / Months
circle one

I HEREBY CERTIFY THAT THE ABOVE TREATMENT IS MEDICALLY NECESSARY:

Physician Signature: _____