McLaren
PORT HURON

Patient Identification

Physical Therapy Prescription

☐ **Port Huron Office** 3504 Pine Grove Ave Port Huron, MI 48060 (810) 385-5531 • Fax: (810) 385-5561	☐ **Lexington Community Health Center** 5730 Main Street Lexington, MI 48450 (810) 359-8193 • Fax: (810) 359-8413
☐ **Marysville Community Health Center** 3350 Gratiot Blvd, Ste E Marysville, MI 48040 (810) 364-1230 • Fax: (810) 364-0483	☐ **Yale Community Health Center** 7470 Brockway Rd Yale, MI 48097 (810) 387-3211 • Fax: (810) 387-2279

Patient Name: _____ **Date:** _____

ICD-10 Diagnosis: _____

_____

Surgical Procedure: _____

Special Requests / precautions _____

_____

_____

_____

_____

_____

TREATMENT RECOMMENDATIONS

☐ Evaluate and treat ☐ Home exercise instruction only ☐ Orthotics

☐ Other: _____

_____

Frequency of Rx: ☐ 3 times / week ☐ 2 times / week

Duration: ☐ 3-4 weeks ☐ 6 weeks

Other: _____

_____

I certify the need for these services furnished under this plan of treatment and while under my care.

_____ _____

Physician Signature Date / Time

Physician Order

PO, Form# 3168, 10/17