



CENTRAL SCHEDULING
Phone: 205-278-2250
Fax: 205-543-2034
www.ironcitypt.com

Physical Therapy Prescription

Patient Name: _____ Date: ____/____/____

Date of Birth: ____/____/____ Sex: M F

Phone: (____) _____ Email: _____

Diagnosis Area: _____

ICD-10: _____

DOI or Surgery Date: ____/____/____ Type of Surgery: _____

Precautions/Limitations: _____

Type of Therapy: [] Physical Therapist: Evaluate and treat [] Occupational Therapist: Evaluate and treat [] Functional Capacity Evaluation (FCE)

Treatment Frequency: _____ times per week for _____.

Return to Physician Date: ____/____/____

Clinic Location: [] Main Clinic 2729 3rd Avenue South Birmingham, AL 35223 [] ACIPCO Clinic, Eagan Center for Wellness 1501 31st Avenue N Birmingham, AL 35207

Physician Signature: X _____ Date: ____/____/____

Physician Name (print): _____

Phone: (____) _____ Fax: (____) _____

Please fax this prescription to 205-543-2034. THANK YOU!

[] Check if more referral pads are needed.