Iron City Physical Therapy
Stronger Every Day™

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**
  201 Office Park Drive, Suite 150
  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.*