

Patient Request for Physician's Order

Patient Name \_\_\_\_\_ is requesting to be evaluated and treated by Premiere Rehab, LLC for:

Complaints of pain at: 0 1 2 3 4 5 6 7 8 9 10 (out of 10)

(Therapist Please Fill Out)

Arm Shoulder Wrist Hand Elbow  
Forearm Neck Jaw Back Low Back Hip  
Groin Knee Ankle Leg Foot

On Right / Left/ Bilateral Side(s)

And/Or Recent Joint Repair/Replacement of:

Hip Shoulder Knee Elbow Other

(Physician Please Fill Out)

Therefore an Order for: PT OT ST

Is recommended to address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ (ICD-9/Description)

Using: Ultrasound Short Wave Diathermy E-stim

Light Therapy Hot/Cold Packs Paraffin

Requested by: \_\_\_\_\_ (Physician signature)

UPIN#(required) \_\_\_\_\_ Date \_\_\_\_\_

When completed, Please Fax to 317-542-7682. We will contact the patient and schedule an appointment within 24-48hours.