8200 Stockdale Hwy, Ste B2,
Bakersfield, CA, 93311

tel: (661) 282-8584
fax: (661) 727-0005

Patient's Name: _____

Phone: _____ **DOB:** _____ **Gender:** _____

Referring Doctor: _____ **Phone:** _____

Diagnosis: _____

Frequency: _____ times per week **Duration:** _____ weeks

☐ **Evaluate and Treat**

ADDITIONAL INFORMATION:

The above plan of care is established and will be reviewed every 30 days.
I certify the medical necessity of physical therapy.

Physician Signature: _____

Please populate, sign and fax the referral to the Fax number provided above, or hand deliver it to the clinic location.