Capitol Physical Therapy

Name: _____ Date of Birth: _____

Diagnosis: _____

☐ Evaluate and Treat Frequency: _____ Duration: _____

Instructions: _____

I hereby certify the medical necessity of adding Physical Therapy to this patient's plan of care.

Signature: _____ Date: _____

Sacramento Clinic
2033 Howe Avenue, Suite 110
Sacramento, CA 95825
P: (916) 446-1497
F: (916) 446-5959

Elk Grove Clinic
9370 Studio Court, Suite 130
Elk Grove, CA 95758
P: (916) 714-1177
F: (916) 714-3577

Roseville Clinic
8211 Sierra College Blvd, Suite 400
Roseville, CA 95661
P: (916) 782-2761
F: (916) 751-2430

www.capitolpt.com

Thank you for this referral!