



MEDICAL PRESCRIPTION FOR PHYSICAL THERAPY (Fax Ready)

Doctor:	Therapist: Matthew Luginbuhl, P.T. 465 Silas Deane Highway Wethersfield, CT 06109
Fax:	Fax: 860-875-6423
Phone:	Phone: 860-306-6423
RE: PRESCRIPTION FOR SERVICES – PLEASE REVIEW, COMMENT, AND RETURN.	
Patient's Name:	DOB:
Parent's Name:	Cell Phone:
	Home Phone:
Home Address:	
First Listed Diagnosis:	ICD-9:
Co-Existing Conditions:	ICD-9:
Historical Conditions:	ICD-9:
Prescription: Physical Therapy Evaluation And Treatment. Frequency and duration to be determined by PT plan of care following evaluation.	
Additional Notes:	
Provider Signature:	Date:

CONFIDENTIALITY NOTICE: The documents accompanying this fax transmission contain confidential information from the office of PediaFlex Therapy Center, LLC. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party and is required to destroy the information after its' stated need has been fulfilled. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for return of these documents.