



Patient Name _____

Diagnosis _____ ICD10 _____

OUTPATIENT REHABILITATION ORDER

EVALUATE AND TREAT

SPECIFIC MODALITIES/PROCEDURES/BRACING:

TESTING/ASSESSMENT:

Isokinetic Testing

Balance Assessment

SPECIAL INSTRUCTIONS/PRECAUTIONS:

Frequency _____ /week

Duration _____ weeks

PROVIDER SIGNATURE: _____ DATE _____

All rehabilitation must be authorized by a prescription from a physician or VSU Student Health Services.

Provider signature above indicates the rehabilitation plan is medically necessary for the patient and diagnosis named above.

Scan to schedule an appointment:



<https://bit.ly/CEMR-ATClinic--NewPatient>

On the Campus of Valdosta State University:
 2525 Patterson Street, Valdosta, GA 31698