REHAB ACCESS
PHYSICAL THERAPY

Physical Therapy Prescription

Please send via fax and bring to your first appointment.

Patient Info

Name: ______________________ DOB: ____________

Home Phone: ______________ Cell Phone: ______________

Insurance: ______________________________________

Requested Physical Therapy

☐ Evaluate and Treat ☐ Continue Therapy

☐ Other: ______________________________________

Specific Instructions, Precautions & Goals

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Diagnosis: ______________________________________

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Surgery: ______________________________________

Date: ______________________________________

To best serve you and your patients, please attach or provide any necessary treatment protocols.

Physician Info

Physicians Signature: ______________________________

Date: ______________ Office Phone: ______________

I certify that the above patient is under my care, has been seen within the last 30 days and that this prescription is medically necessary.

We participate with most insurance companies.
For more information on accepted insurance plans, please visit Insurance.RehabAccess.com

RehabAccess.com

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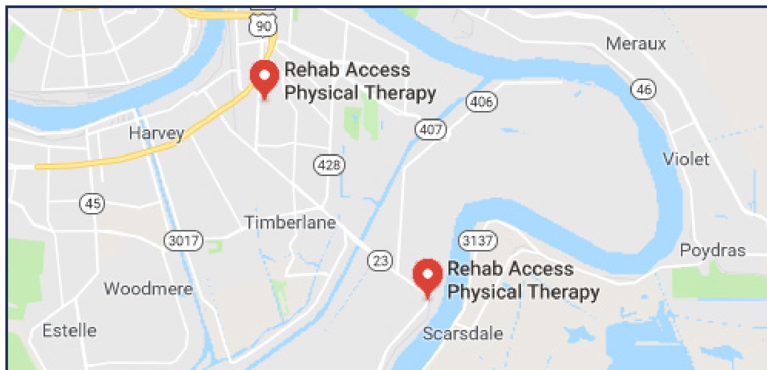
Our Locations



Gretna	**Belle Chasse**
1712 Stumpf Blvd	8397 Highway 23 #101
Gretna, LA 70056	Belle Chasse, LA 70037
P: 504.365.1020	P: 504.398.2004
F: 504.365.1080	F: 504.398.2006