

**Kip Hartman, DPT**

Patients Name: \_\_\_\_\_

Patients DOB: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Special Orders/Precautions: \_\_\_\_\_

Physical Therapy  Evaluate & Treat  Follow-up w/Primary Physician  Follow-up Date: \_\_\_\_\_

Frequency & Duration \_\_\_\_\_ Times/Wk. \_\_\_\_\_ Wks. \_\_\_\_\_ As per PT Discretion

I certify this patient is under my care and Physical Therapy services are necessary.

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Physician Name: \_\_\_\_\_

Conveniently located across from Upper Peninsula Medical Center