ORTHOPEDIC: Brett Pinkney, MPT, Owner
Tiffany Loeffler, DPT
WOMEN'S HEALTH: Mollie Tanjoco, MPT
HAND REHABILITATION: Sharon Gaebler, OTR, CHT

Therapist Appt. ______________________ Date/Time: ______________________

Name: ____

Phone: ______________________ Cell: ______________________

Insurance: ______________________ ID #: ______________________

Diagnosis: ____

____

☐ ***EVALUATE AND TREAT***
___ Back/Neck Care
___ S/P Orthopedic
___ Shoulder
___ Hip
___ Knee Rehab
___ Ankle/Foot
___ Balance and Vestibular

___ **CERTIFIED HAND THERAPY**
___ AROM
___ PROM
___ Wound Care
___ Splint Fabrication
___ Other ______________
____

___ **WOMENS' HEALTH**
___ Pre/Post Natal
___ Pelvic Pain
___ Incontinence
___ Other ______________
____

☐ ***Specific Instructions:*** ____

____

____

Precautions (if any): ____

____

Frequency/Duration: ____

Physician Signature: ______________________________ **Date:** ______________

Print Physician's Name: ____

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588 N. Sunrise Avenue • Suite 100
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www.familyphysicaltherapist.com