



**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient Phone #** \_\_\_\_\_ **DOB:** \_\_\_\_\_

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

**Area To Be Treated:** \_\_\_\_\_

**PHYSICAL THERAPY** - Evaluate and Treat

**Special Instructions / Precautions:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Print Provider's Name:** \_\_\_\_\_

**Office Phone #** \_\_\_\_\_

**Referring Provider Signature:**

\_\_\_\_\_

I hereby certify that the services indicated  
above are medically necessary

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**EVANS**

415 TOWN PARK BLVD  
EVANS, GA 30809

**GROVETOWN**

5003 STEINER WAY, SUITE 2  
GROVETOWN, GA 30813

**SOUTH AUGUSTA**

2115 WINDSOR SPRING RD, SUITE 23  
AUGUSTA, GA 30906

**THOMSON**

150 MAIN STREET  
THOMSON, GA 30824