

Patient Name: _____

Phone: _____

Physician: _____

Follow Up Date: _____

Diagnosis: _____

ICD-10: _____

Insurance: _____

☐ Physical Therapy

☐ Functional Capacity Evaluation

☐ NCV/EMG Testing

☐ Work Hardening Programs

☐ Joint Musculoskeletal Ultrasound (MSKUS)

☐ Other _____

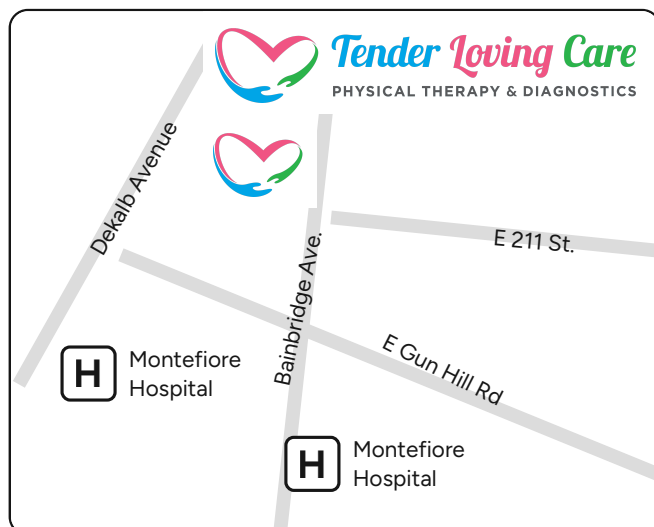
Precautions / Special Instructions / Contraindications

Frequency / Duration _____ times per week for _____ weeks.

I hereby certify these services as medically necessary for this patient's plan of care.

Physician Signature: _____ Date: _____

Doctors can now refer online: TLCreferral.com



To make an appointment,
please call: 718-652-3535

Fax: 718-652-2323

Text: 917-204-8093

tenderlovingcarept.com

3555 Bainbridge Avenue
Bronx, NY 10467 US

****We have free parking and
are accessible by
public transportation.

☐ Check here if you need more referral pads.