PHYSICAL THERAPY CONSULTATON

NAME *(Last, First, M.I.) (For P.T. Use Only)*

FROM: *(Requesting Activity)*

DATE

PROVISIONAL DIAGNOSIS - REASON FOR REQUES*T (Complaints/findings)*

SIGNATURE OF PROVIDER

PATIENT STATUS
☐ IN ☐ OUT

PLACE OF CONSULTATION
☐ BEDSIDE ☐ DEPT

☐ EMERGENCY
☐ ROUTINE

MONTH	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

REMARKS *(For P.T. Use Only)*

STATUS

SCHEDULE

PHYSICAL THERAPY REPORT

PATIENT IDENTIFICATION

AF FORM 1535, 19820101 *(EF-V2)*

PHYSICAL THERAPY CONSULTATION *(Continued)*