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PHYSICIANS PLAN OF CARE—REFERRAL

PATIENT: \_\_\_\_\_ DATE: \_\_\_\_\_

DIAGNOSIS: \_\_\_\_\_ NEXT PHYSICIAN VISIT \_\_\_\_\_

FREQUENCY AND DURATION: \_\_\_\_\_

DATE OF INJURY: \_\_\_\_\_ DATE OF SURGERY: \_\_\_\_\_

Rx [ ] Evaluation and Treatment as Necessary

I certify the need for these services furnished under this plan of treatment while under my care.

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

Physician Printed Name \_\_\_\_\_

