MAJOR HAÜS
#58 North Montrose Avenue
P.O. Box N-4119
Nassau, Bahamas
Phone: (242) 601-5145

www.majorchangesrehab.com

Email: info@majorchangesrehab.com
Website: www.majorchangesrehab.com
Facebook: www.facebook.com/majorchangesrehab
Instagram: www.instagram.com/majorchanges.rehab

Patient Name:

____

Diagnosis:

____

____

Frequency / Duration ___________ Times Per Week for ___________ Weeks

EVALUATE & TREAT

- ☐ Therapeutic Exercise
- ☐ Home Therapy
- ☐ Gait Training
- ☐ Range of Motion
- ☐ Joint / Soft Tissue Mobilization
- ☐ Manual Therapy
- ☐ Back / Body Mechanics
- ☐ Balance / Fall Prevention
- ☐ Ultrasound
- ☐ Electrical Stimulation
- ☐ Hot / Cold Packs
- ☐ Water Therapy
- ☐ Other

  ____

  ____

Medical Precautions:

____

____

The above plan of care is established and will be reviewed every 30 days. I certify the medical necessity of therapy.

Physician's Name: ____________________________ Date: ________________

Physician's Signature: ____

PLEASE DO NOT EMAIL THIS PRESCRIPTION. This electronic version of the Physician's Referral Form / Prescription is provided for your convenience. With respect to responding to this form, please do not forward via email. Please populate, print and sign a hardcopy that may be faxed or hand delivered to our facility.