MICHELLE FOOSANER, MS PT
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415-606-9773

MEDICAL CLEARANCE FORM/PRESCRIPTION

Patient Name: _____
Date of Birth: _____

PHYSICAL THERAPY: EVALUATION AND TREATMENT
Treating Diagnosis/ICD-9: _____

Please indicate any activity precautions and duration for which they apply:_____
_____

_____ _____
Signature of Referring Physician Date

_____ _____
Please Print Physician's Name CA License #

Additionally, please indicate if the abovementioned patient has had or currently presents with any of the following, and provide additional information as appropriate:

Hip subluxation: yes □ no □ _____
Scoliosis: yes □ no □ _____
Heart disease: yes □ no □ _____
Seizure disorder: yes □ no □ _____
High blood pressure: yes □ no □ _____
Hydrocephalus/VP Shunt: yes □ no □ _____
Diabetes: yes □ no □ _____
Kidney dysfunction: yes □ no □ _____
Wounds: yes □ no □ _____
Other: (please explain)_____

If you have any questions or would like to speak directly with one of our therapists, please feel free to contact us at the number or email address above.

Thank you!!