MOTION ANALYSIS LAB REQUEST – SPORT EVALUATION Prescription/Letter of Medical Necessity

VISIT TYPE Running Analysis Contact Number/Email Contact Number/Email Page 1 Contact Number/Email Co	Patient Name:		DOB:
Running Analysis Long Distance Runner Sprinter Hamstring injury ACL Return to Sport Analysis Throwing Analysis Do you want them throwing from a pitching mound? Yes No Other	VISIT TYPE		
Sprinter Hamstring injury ACL Return to Sport Analysis Do you want them throwing from a pitching mound? Yes No Other			
Hamstring injury ACL Return to Sport Analysis Throwing Analysis Do you want them throwing from a pitching mound? Yes No Other		er	
ACL Return to Sport Analysis Throwing Analysis Do you want them throwing from a pitching mound? Yes No Other TREATMENT ORDER Required: Physical Therapy Evaluation (97161, 97162, 97163) DIAGNOSIS: INVOLVED LIMB (CHECK ONE) Select one: Left Leg RIGHT Leg BILATERAL PRECAUTIONS/CONTRAINDICATIONS: The therapy service for the above named patient is medically necessary. A licensed therapist will treat my patient.			
Throwing Analysis Do you want them throwing from a pitching mound? Yes No Other			
Do you want them throwing from a pitching mound?			
Other TREATMENT ORDER Required: Physical Therapy Evaluation (97161, 97162, 97163) DIAGNOSIS:		wing from a pitching mound?	Ves ¬No
Required: Physical Therapy Evaluation (97161, 97162, 97163) DIAGNOSIS: INVOLVED LIMB (CHECK ONE) Select one: LEFT LEG RIGHT LEG BILATERAL PRECAUTIONS/CONTRAINDICATIONS: The therapy service for the above named patient is medically necessary. A licensed therapist will treat my patient. Physician's signature Printed Name Date Contact Number/Email ***Please fax orders & clinical information to 936-267-7904			ics had
DIAGNOSIS: INVOLVED LIMB (CHECK ONE) Select one:	TREATMENT ORDER		
Select one: Left Leg RIGHT Leg BILATERAL	Required:	Physical Therapy Evaluation	(97161, 97162, 97163)
Select one: LEFT LEG	DIAGNOSIS:		
LEFT LEG RIGHT LEG BILATERAL PRECAUTIONS/CONTRAINDICATIONS: The therapy service for the above named patient is medically necessary. A licensed therapist will treat my patient. Physician's signature Printed Name Date Contact Number/Email ***Please fax orders & clinical information to 936-267-7904	INVOLVED LIMB (CHECK ONE)		
RIGHT LEG BILATERAL PRECAUTIONS/CONTRAINDICATIONS: The therapy service for the above named patient is medically necessary. A licensed therapist will treat my patient. Physician's signature Printed Name Date ***Please fax orders & clinical information to 936-267-7904	Select one:		
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Physician's signature Printed Name Contact Number/Email ***Please fax orders & clinical information to 936-267-7904	PRECAUTIONS/CONTRAINDICATION	<u>s:</u>	
Contact Number/Email ***Please fax orders & clinical information to 936-267-7904	The therapy service for the above nan	ned patient is medically necessary	A licensed therapist will treat my patient.
&	Physician's signature	Printed Name	Date
Texas Children's Hospital	Contact Number/Email		***Please fax orders & clinical information to 936-267-7904
Texas Children's Hospital	Š		
	Texas Children's Hospital		