
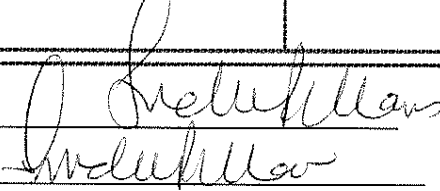


MD Request Form	
	STAR Physical Therapy 25389 Madison Ave. #101 Murrieta, CA 92562 Phone : 1-800-280-1339 Fax: 1-866-319-7682
Date: February 16, 2007	
To: Dr. Pillai Fax: 9516001132	Regarding Patient: Brooks, Julia DX: R Labral s/s
To maximize this patients recovery and avoid further impairment I recommend the patient named above receive the item(s) stated:	
Item:	Physical therapy referral
Reason:	Julia was seen for PT in October. She was having no pain til recently she started aggressively participating again in softball. After evaluating her, she will benefit from skilled PT. ROM: WFL with pain with ABD and HBB. Mod hypomobile T/S Strength: Flex/ABD 4/5 IR/ER 4/5 TTP supraspinatus and infraspinatus (+) Labral s/s Recommendations: 2x/week for 2 weeks
When:	Immediately :
Therapist Name: Hana Kim, PT	
(To be completed by the MD)	
<input type="checkbox"/> I concur with the above recommendations.	<input type="checkbox"/> Other: _____
Name of MD: _____ Signature of MD: 	Date: <u>2/19/07</u>
Please complete and FAX BACK to STAR Physical Therapy at 1-866-319-7682 . Thank you.	