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Name: _____ Date of Birth: _____

Diagnosis/ICD-10: _____

☐ Evaluate & Treat

☐ Redcord (neuromuscular activation)

☐ Evaluate & Report

☐ Injury Prevention Screen & Report

☐ Deep Tissue Laser Therapy

☐ Other: _____

☐ Other: _____

Special Instructions: _____

Frequency/Duration: _____

Physician Signature: _____ Date: _____