

# FAX

<b>Date:</b>	01/22/2026
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<b>To:</b>	
<b>Phone</b>	
<b>Fax Phone</b>	+19725329272

<b>From:</b>	Kelsey O'Connor
<b>Phone</b>	15855820007
<b>Fax Phone</b>	Anonymous

<b>NOTE:</b>	
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ATHELAS WPT  
THE WHITE HOUSE PENNSYLVANIA AVENUE  
, WA 20500

Phone:  
Fax: (585) 551-2482



# FAX

**To:** John Doe

**From:** Wagner Kramer PT -  
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**Fax:** 19725329272

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**Date:** 01/22/2026

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**Phone:**

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**Patient:** Poc Tracker

**Enclosure:**

Initial Evaluation -

Thank you for your timely return of the signed Initial Evaluation document so that we may continue treating your patient.

Thank you!

**IMPORTANT:** This facsimile transmission contains confidential information, some or all of which may be protected health information as defined by the federal Health Insurance Portability & Accountability Act (HIPAA) Privacy Rule. This transmission is intended for the exclusive use of the individual or entity to whom it is addressed and may contain information that is proprietary, privileged, confidential and/or exempt from disclosure under applicable law. If you are not the intended recipient (or an employee or agent responsible for delivering this facsimile transmission to the intended recipient), you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. Please notify the sender by telephone (number listed above) to arrange the return or destruction of the information and all copies.

# Initial Evaluation



**Patient Name** POC Tracker

**Date of Birth** 01/01/2026

**Rendering Provider** Wagner Kramer PT

**Referring Provider** JOHN DOE

**Plan Of Care Begins** 01/22/2026

**Visit #** 1

**Date of Original Visit** 01/22/2026

**Diagnosis Code** T17.900A - Unspecified foreign body in respiratory tract, part unspecified causing asphyxiation, initial encounter

## PLAN

I have recommended the following therapy plan:

*Poc Tracker will be seen 2 times per week for 12 weeks starting 01/22/2026 and ending 04/15/2026.*

**Signature**

*Wagner Kramer*

Wagner Kramer, PT License 0000000000

Signed: 2026-01-22 12:33 PM MST

**Plan of Care Approval for POC Tracker**

Please fax signed and dated plan of care approval to 15855512482

**Electronically signed by: Wagner Kramer PT**

Thank you for this referral.

We are required to obtain an approval for this plan of care. You may approve the plan of care and make any changes to the plan of care by commenting below.

Please sign below stating you have reviewed this Plan of Care and agree with our assessment. Please do not hesitate to contact the treating therapist if you have any questions, concerns, or would like to make any changes to this Plan of Care. Thank you for this referral and trusting us with your patient.

**Physician's Signature**

**Date**