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PHYSICAL THERAPY

Date: ______________________

Patient's Name: ____________________________________ DOB: ______________________

DIAGNOSIS: ____________________________________ **ICD 10:** ______________________

Date of Injury/Onset Date/Surgery: ____

THERAPY TYPE / PROCEDURES

☐ Evaluate & Treat

- ☐ **Therapeutic Exercise / Activities**
  - ☐ AROM/AAROM/PROM/Strength
- ☐ **Modalities / Physical Agents**
  - ☐ Electrical Stimulation
  - ☐ Ultrasound
  - ☐ Cold Pack / Moist Heat
  - ☐ Paraffin Wax
  - ☐ Traction
- ☐ **Manual Therapy**
  - ☐ Joint/Soft Tissue Mobilization
- ☐ **Education / Home Exercise**
- ☐ **Gait Training**
- ☐ **Neuromuscular Re-education**
- ☐ **Balance & Vestibular Rehab**
- ☐ **Lymphedema Therapy**
- ☐ **Iontophoresis / Phonophoresis**
  (with 4mg / ml. inj. Dexamethasone 30cc use as directed)
- ☐ **Weight Bearing Status**
  - ☐ FWB
  - ☐ PWB (%)
  - ☐ WBAT
  - ☐ NWB
- ☐ **Other** ______________

Precautions / Special Instruction ____

FREQUENCY:

☐ Therapist Discretion ☐ 5 X Week ☐ 3 X Week ☐ 2 X Week

DURATION:

☐ 8 Weeks ☐ 6 Weeks ☐ 4 Weeks ☐ 60 days ☐ 30 days ☐ Other ______________

I certify that the rehabilitation procedures prescribed for this patient are medically and therapeutically necessary.

______________________________ ______________________________

Physician's Signature / Date NPI#

______________________________ ______________________________

Physician's Name Phone# Fax#