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www.ptoptions.com

Name ____ Date __________

Diagnosis ____

Precautions ____

Weight Bearing Status ____

Frequency/Duration ____

☐ **Physical Therapy Eval & Treat:**
☐ Therapeutic Exercise
☐ Range of Motion Exercise
☐ Gait Training
☐ Heat and Cold
☐ Ultrasound
☐ Paraffin
☐ Electrical Stimulation
☐ Laser
☐ Manual Traction
☐ Joint Mobilization
☐ Soft Tissue Mobilization/MFR
☐

☐ Vestibular Therapy
☐ Balance/Proprioception
☐ Home Assessment
☐ ADL Skills/Functional Training
☐ Wheelchair Assessment
☐ Postural Stabilization Exercise
☐ Orthotic/Prosthetic Check-out
☐ Other ____________________
____

To achieve optimal recovery, the patient requires the above prescribed treatment as a medical necessity for the designated diagnosis.

MD Name _______________________________ Phone _____________

MD Signature ____________________________ Date _______________
NPI __________________________

Comments: ____

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