ADVANCED
PHYSICAL THERAPY

Appt: Time & Date _____
Bring: Treatment prescription, insurance card/info

Treatment Prescription

Name _____

Diagnosis _____

Medical Precautions _____

❑ Evaluate and Treat ❑ PT/OT

1 2 3 4 5 Visits per Week for _____ Weeks ❑ As Needed

Treatment Evaluations

❑ Aquatic Rehab Evaluation
❑ Extremity Evaluation & Exercise
❑ Foot Orthotics Evaluation & Application
❑ Functional Capacity Evaluation
❑ Home TENS Evaluation & Application
❑ Maternal Wellness
  ❑ Prenatal ❑ Postnatal
  ❑ Weeks Gestation _____
❑ McConnell Evaluation & Application
❑ Pediatric Evaluation

Occupational Therapy

❑ Carpal Tunnel
❑ Hand Tendon Repair
❑ Hand Therapy
❑ Lymphedema
❑ Splinting

Other _____

_____

_____

_____

Modalities

❑ Cryotherapy
❑ C-Traction/Unloading
❑ Diathermy
❑ Hot Packs
❑ Interferential
❑ Iontophoresis
❑ Muscle Stimulation
❑ P-Traction/Unloading
❑ Ultrasound

Procedures

❑ ACL Rehab
❑ AlterG Anti-Gravity Treadmill
❑ Aquatic/Pool Therapy
❑ Astym
❑ Back Rehab
❑ Bracing/Splinting
❑ Gait Training
❑ Manual Therapy
❑ Massage
❑ Neuromuscular Re-education
❑ Rotator Cuff Rehab
❑ Therapeutic Activities/Exercises
❑ Trunk Stabilization Program

I hereby certify these services as medically necessary for the patient's plan of care.

Signature _____ Date _____

NPI# _____