THERAPY PROS

Patient Name: _____ **Phone:** _____

Physician: _____ **Follow Up Date:** _____

Diagnosis: _____

Insurance: ❑ **PPO** ❑ **Medicare** ❑ **Work Comp** ❑ **Tricare** ❑ **Other**

❑ Physical Therapy Evaluation & Treatment

❑ Iontophoresis	❑ Ultrasound	❑ Therapeutic Exercise	❑ Home Exercise Pgm.
❑ Hot / Cold packs	❑ Traction	❑ Mobilization/Manual Therapy	❑ Balance Training
❑ Paraffin	❑ Electrical Stimulation	❑ Therapeutic Activities	❑ Fall Prevention

Specialty Rehab Programs: ❑ Lymphedema Therapy ❑ Vestibular Rehabilitation

❑ Cardiac Rehabilitation Evaluation (Phase II) ❑ Pulmonary Rehabilitation Evaluation

❑ Phase II (Includes ECG Monitoring)	❑ Dietary Evaluation	❑ Chest Physiotherapy
❑ Unmonitored	❑ Smoking Cessation Program	❑ Titrate FiO2 to keep
❑ Target HR Range_____	❑ Spirometry	SpO2>_____%

Precautions / Special Instructions / Contraindications _____

_____

Frequency / Duration_____times per week for_____weeks.

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

Physician Signature: _____ Date: _____