Dano Napoli, MPT, OCS, Cert. DN

2631 McIngvale Rd., Ste 108
Hernando, MS 38632
Ph: 662.469.9054
Fax: 662.469.9126

Patient: _____

Phone: (h) _____ (c) _____

Diagnosis: _____

Precautions: _____

Surgical Procedure(s): _____

Date of Physician Follow up Apppointment: _____

PHYSICAL THERAPY PROCEDURES

☐ **Evaluate & Treat Appropriately**

- ☐ Therapeutic Exercise
- ☐ PROM/AROM
- ☐ Manual Therapy
- ☐ Back Program
- ☐ Post-op Program
- ☐ Stabilization Exercise
- ☐ Work Conditioning
- ☐ Physical Therapy Procedures
- ☐ Dry Needling
- ☐ Other_____

FREQUENCY/DURATION

Freq: ☐ Daily ☐ 3x/Wk ☐ 2x/Wk ☐ 4x/Wk ☐ 1x/Wk

Duration: _____ weeks

☐ Therapist's Discretion

PROGRAM GOALS

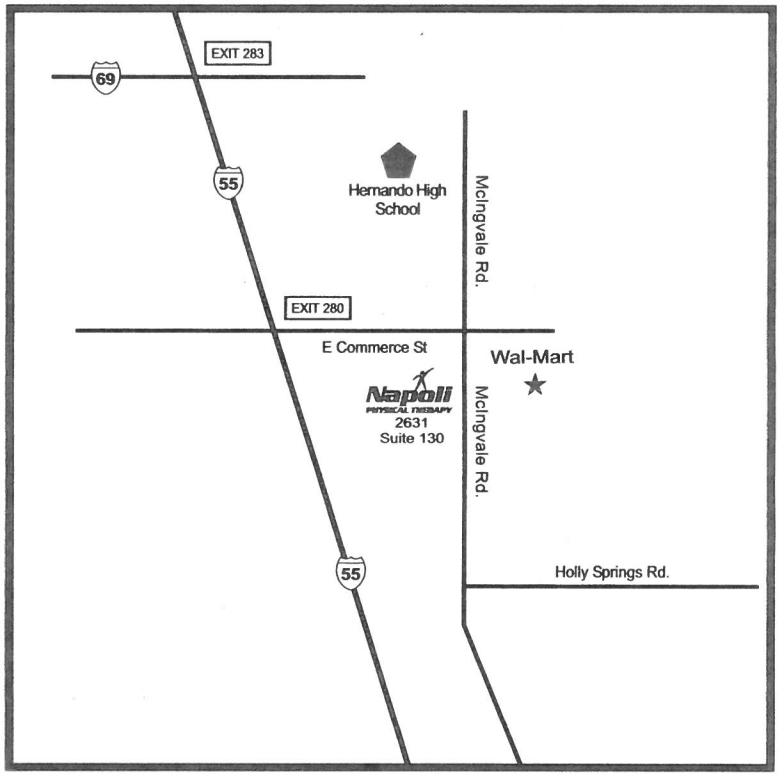
- ☐ Relieve Pain
- ☐ Increase ROM
- ☐ Increase Strength/Endurance
- ☐ Improve Functional Skills
- ☐ Other _____

I certify that the above marked therapy/rehabilitation service is medically necessary:

_____ _____

Physician's Signature *Date*

DIRECTIONS TO OUR FACILITY



For your first visit, please don't forget to bring:

1. Prescription
2. Insurance Card/ Information
3. Comfortable Clothing