NORTHERN ARIZONA
PHYSICAL THERAPY ASSOCIATES

Treatment Prescription

Name: _____

Diagnosis: _____

Phone Number: _____**Alternate Phone #:** _____

ICD10 Code(s): _____

Medical Precautions: _____

1 2 3 4 5 Times/Week _____Weeks_____As needed_____

❑ **Evaluate and treat**

Treatment Prescription

- ❑ Exercise Program
- ❑ Gait Training
- ❑ Home exercise program
- ❑ Joint Mobilization
- ❑ AROM/AAROM
- ❑ PROM
- ❑ Activities of Daily Living
- ❑ Posture, Positioning, Body Mechanics
- ❑ Spine Stabilization

Work Strategies

- ❑ Functional Capacity Exam
- ❑ Physical Reconditioning Program
- ❑ Work Site Analysis
- ❑ Work Conditioning
- ❑ Work Hardening
- ❑ Injury Prevention Program

Modalities & Procedures

- ❑ Ultrasound
- ❑ Electrical Stimulation
- ❑ Moist Heat
- ❑ Cryotherapy
- ❑ Soft Tissue Mobilization
- ❑ TENS
- ❑ Traction
- ❑ IASTM
- ❑ Kinesiotaping

Other:

_____
_____
_____
_____
_____
_____

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

Physicians Signature: _____

Date: _____ NPI#: _____

Physician Phone Number: _____

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