Physical Therapy Specialties

"Superior outcomes through specialty care ..."

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Name: _____ Date: _____

Diagnosis/Condition _____

Surgical Procedure/ICD10: _____

Precautions/Comments: _____

_____

Frequency _____ wk x _____ weeks

❒ Evaluate and Treat

Therapeutic Measures

- ❑ Manual Therapy
  - ❑ Soft Tissue Mobilization
  - ❑ Joint Mobilization
  - ❑ Myofascial Release
- ❑ Integrative Dry Needling
- ❑ Mechanical Traction
  - ❑ Cervical
  - ❑ Lumbar
- ❑ Therapeutic Exercise
  - ❑ Stabilization (cervical / lumbar)
  - ❑ Strengthening
  - ❑ Stretching
  - ❑ ROM (Active / Passive)
  - ❑ Home Exercise Program
  - ❑ Body Mechanics / Posture Ed.
  - ❑ Williams Flexion Program
  - ❑ McKenzie Extension Program
- ❑ Spray & Stretch
- ❑ Gait Training

Modalities

- ❑ Ultrasound
- ❑ Phonophoresis
- ❑ Moist Heat / Cold Packs
- ❑ Paraffin
- ❑ Iontophoresis
- ❑ TENS
- ❑ Electric Stim / IFS

Home Program

- ❑ Home Exercise Program
- ❑ Home Traction (Cervical / Lumbar)
- ❑ TENS /E-Stim Unit
- ❑ Home Muscle Stimulation

Other: _____

_____

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

Physician's Signature: _____ **Date:** _____