PT PLUS
PHYSICAL THERAPY

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

TREATMENT PRESCRIPTION

Name _____

Diagnosis _____

Medical Precautions _____

☐ **EVALUATE & TREAT** ☐ **PT/OT**

1 2 3 4 5 Visits per Week or ____ Weeks ☐ As Needed

Treatment Evaluations

☐ McKenzie Spine Evaluation & Exercise
☐ Williams Flexion Evaluation & Exercise
☐ Extremity Evaluation & Exercise
☐ Foot Orthotics Evaluation & Application
☐ McConnell Evaluation & Application
☐ Maternal Wellness
☐ Prenatal ☐ Postnatal
☐ Weeks Gestation _____
☐ Home TENS Evaluation & Application

Modalities

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

Occupational Therapy

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

Other _____
_____

Procedures

☐ Manual Therapy
☐ Massage
☐ Bracing
☐ Trunk Stabilization Exercise
☐ Back Rehab
☐ Rotator Cuff Rehab
☐ ACL Rehab
☐ Gait Training
☐ Therapeutic Exercises
☐ Neuromuscular Re-education
☐ ASTYM

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

Signature _____ Date _____

NPI# _____