Patient Name: _____

Patient Phone #: _____

Diag: _____

_____

- ❑ Eval & Tx _____ / wk x _____ wks
- ❑ Therapeutic Exs
- ❑ Balance Training
- ❑ Manual Therapy
- ❑ Joint Mobilization
- ❑ ROM / AROM / PROM
- ❑ Neuromuscular Re-education
- ❑ Gait Training
- ❑ Pulmonary Rehab
- ❑ Ultrasound
- ❑ Electrical Stimulation
- ❑ Vestibular Rehabilitation
- ❑ Lymphedema Management
- ❑ TMJ Treatment
- ❑ Traction : Cervical / Lumbar
- ❑ Iontophoresis / Phonophoresis
- ❑ Functional Capacity Evaluation
- ❑ Other

I certify that this service is reasonable and necessary for this patient and indicate by signature my approval of the stated plan of care and goals for the next 30 days of treatment.

Physician's Signature: _____ Date: _____

Phone: _____

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