REHABILITATIVE THERAPY

Patient's Name: _____ Date: _____

Dx: _____

Area/Part To Be Treated: _____

Precautions: _____

WB Status: _____

Frequence 1 2 3 4 5 /week Duration _____ weeks

- ☐ Occupational Therapy
- ☐ Physical Rehab
- ☐ Therapeutic Rehab
- ☐ Post Surgical Rehab
- ☐ Stroke Rehab
- ☐ Neuromuscular Re-education
- ☐ Iontophoreses
- ☐ Ultrasound
- ☐ Electrical Muscle Stimulation/TENS
- ☐ Myofacial Release
- ☐ Massage/Soft Tissue Work
- ☐ Physical Performace Testing
- ☐ Functioal Capacity Evaluations
- ☐ Pre-Employment Testing
- ☐ Evaluate and Treat
- ☐ Other _____

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

_____ _____

Physician's Signature Date:

☐ Please check here if more script pads are needed