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Name: ________________ DOB: ________________

Diagnosis: ________________

ICD9: ________________ Precautions/contraindications: ________________

____ **Evaluate & Treat** ____ **Pre-surgical exercise training and education**

Programs-

____ Neck ____ Biofeedback ____ Occupational Therapy

____ Back ____ TMJ Dysfunction ____ Hand Therapy

____ Joint ____ Vestibular Rehab ____ Functional Capacity Evaluation

____ Gym Program ____ Balance Training ____ Ergonomic Evaluation

____ Water Therapy ____ Golf Evaluation & Conditioning ____ Home Safety Evaluation

____ Gait Training

Women's Health-

____ Biofeedback/Incontinence Training ____ Pelvic Pain ____ Pregnancy ____ Osteoporosis

Modalities as needed ____ Cervical Traction ____ Lumbar Traction ____

Frequency/duration: ____ times per week for ____ weeks

Other instructions: ________________

I certify that I have examined the patient and physical therapy is medically necessary for the health of the patient.

Signature ________________ Date ________________

Rev 3-10