Optimum Recovery RehaB
PHYSICAL THERAPY & REHABILITATION

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Patient Name:_____ **DOB:**_____

Physician:_____ **Follow up date:** _____

Diagnosis:_____

Precautions/ Comments: _____

❑ Evaluate & Treat

❑ Modalities
- ❑ Hot / Cold packs
- ❑ Ultrasound
- ❑ Electrical Stimulation
- ❑ Paraffin
- ❑ Traction

❑ Therapeutic Exercise
- ❑ Range of Motion
- ❑ Strengthening
- ❑ Stretching

❑ Neuromuscular Re - Education
❑ Gait Training
❑ Manual Therapy
❑ Kinetic / Therapeutic Activities
❑ Taping
❑ Body Mechanics
❑ Postural Instruction
❑ Home Exercises
❑ Work Conditioning
❑ Other

Frequency of Treatment:

Standard Treatment Plan -3 days a week ❑ 4 ❑ 6 ❑ 8 weeks

❑ Other frequency of treatment _____ days a week

Physician's Notes: _____

_____

I hereby certify that Physical Therapy is medically necessary for this patient's plan of care.

_____ _____

Signature Date