



**TREATMENT PRESCRIPTION**

PATIENT'S NAME: \_\_\_\_\_ SS#: \_\_\_\_\_

PATIENT'S ADDRESS: \_\_\_\_\_

PATIENT'S PHONE: \_\_\_\_\_ PATIENT'S D.O.B.: \_\_\_\_\_

MEDICARE PATIENT: MEDICAL BENEFIT TRADITIONAL PART B:  YES  NO

MEDICARE #: \_\_\_\_\_

SECONDARY INSURANCE#: \_\_\_\_\_

MEDICAL PRECAUTIONS: \_\_\_\_\_

FREQUENCY / DURATION: \_\_\_\_\_

**EVALUATE & TREATMENT AS INDICATED**       **CONTINUE P.T.**

- |   |  |
|---|--|
| <input type="checkbox"/> Heat / Cold Compress   | <input type="checkbox"/> Strengthening/Ther-ex (97110) |
| <input type="checkbox"/> Ther-activities (97530)  | <input type="checkbox"/> Transfer Training             |
| <input type="checkbox"/> Balance, Coordination, Proprioception<br>and Postural Training (97112) | <input type="checkbox"/> Gait Training (97116)         |
| <input type="checkbox"/> HEP  | <input type="checkbox"/> FWB                           |
| <input type="checkbox"/> AROM   | <input type="checkbox"/> WBAT                          |
| <input type="checkbox"/> AAROM  | <input type="checkbox"/> Non Weight Bearing            |
| <input type="checkbox"/> PROM   | <input type="checkbox"/> Bed Mobility Training         |
| <input type="checkbox"/> ADL Training / Safety (97535)  | <input type="checkbox"/> Joint Mobilization (97140)    |
|   | <input type="checkbox"/> Massage (97124)               |

NOTES/DX: \_\_\_\_\_

I certify the above service's are medically necessary for the patient's plan of care.

Healthcare Professional Name: \_\_\_\_\_

UPIN# \_\_\_\_\_ NPI: \_\_\_\_\_

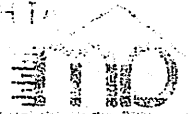
Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Healthcare Professionals Signature: \_\_\_\_\_

Date: \_\_\_\_\_

TREATMENT PRESCRIPTION



PATIENT'S NAME: \_\_\_\_\_

SSN: \_\_\_\_\_

PATIENT'S ADDRESS: \_\_\_\_\_

PATIENT'S PHONE: \_\_\_\_\_

PATIENT'S DOB: \_\_\_\_\_

MEDICAL HISTORY: \_\_\_\_\_

PHYSICIAN'S NAME: \_\_\_\_\_

PHYSICIAN'S ADDRESS: \_\_\_\_\_

PHYSICIAN'S PHONE: \_\_\_\_\_

PHYSICIAN'S FAX: \_\_\_\_\_

PHYSICIAN'S LICENSE NO.: \_\_\_\_\_

PHYSICIAN'S STATE: \_\_\_\_\_

PHYSICIAN'S SPECIALTY: \_\_\_\_\_

PHYSICIAN'S HOURS: \_\_\_\_\_

PHYSICIAN'S MAILING ADDRESS: \_\_\_\_\_

PHYSICIAN'S FAX: \_\_\_\_\_

PHYSICIAN'S LICENSE NO.: \_\_\_\_\_

PHYSICIAN'S STATE: \_\_\_\_\_

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