BACK TO HEALTH
PHYSICAL THERAPY ASSOCIATES

P: 201.833.0234 | F: 201.645.4735

PHYSICAL THERAPY AND OCCUPATIONAL THERAPY PRESCRIPTION AND CERTIFICATE OF MEDICAL NECESSITY

Name _____ Date _____

Diagnosis _____

Frequency _____ x per week for _____ weeks

Please select:

☐ **Physical Therapy**
☐ **Occupational Therapy**

☐ **In-Home Rehab** ☐ **Outpatient Clinic**

☐ EVALUATION AND TREATMENT

- ☐ Therapeutic Exercise
- ☐ PROM, AAROM, AROM
- ☐ Strengthening/Conditioning
- ☐ Joint Mobilization
- ☐ Pain Management
- ☐ ADL Training
- ☐ Energy Conservation
- ☐ Gait Training
- ☐ Balance Training
- ☐ Fall Prevention
- ☐ Functional Training/Activities
- ☐ Patient Education
- ☐ Ultrasound
- ☐ E-Stim

Other/Comments _____

I certify that the above prescribed treatment is medically necessary to achieve optimum recovery.

Physicians Signature _____ Date _____

Print Name _____

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