



PHYSICAL THERAPY ASSOCIATES

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## 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 \_\_\_\_\_