ELEVATE
PHYSICAL THERAPY

Tel: 256-580-5051 Fax: 256-646-2532

Patient Name: _____ **DOB:** _____

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

Diagnosis/ICD-10: _____

Special Instructions: _____

❑ **Evaluate & Treat**

Modalities	**Procedures**	**Special Programs**
❑ Moist Heat/Ice	❑ Therapeutic Exercise	❑ Postural Education
❑ Electrical Stimulation	❑ Joint Mobilization	❑ Wellness Training
❑ Ultrasound	❑ Soft Tissue Mobilization	❑ Home Exercises Program
❑ Traction	❑ Gait Training	❑ Balance
	❑ Neuromuscular Re-education	❑ Dry Needling

Frequency of Treatment:

Standard Treatment Plan 2-3 times per week for: ❑ 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 _____

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