PHYSICAL THERAPY

NAME: ______________ **DATE OF BIRTH:** ______________
PHYSICIAN: ______________ **NPI #** ______________
PHYSICIAN ADDRESS: ______________
PHYSICIAN PHONE: ______________ **PHYSICIAN FAX:** ______________
DIAGNOSIS: ______________

ICD 10 CODE: ______________

DATE OF SURGERY: ______________ **WB STATUS:** ______________
DATE OF INJURY: ______________ **CONTACT NUMBER:** ______________
SPECIAL CONSIDERATIONS / PRECAUTIONS: ______________

Frequency: ☐ Per DPT Recommendation ☐ Other: ______________

PHYSICAL THERAPY SERVICES:

☐ **EVALUATE & TREAT:**

- ☐ Range of Motion
  - ☐ Active
  - ☐ Active Assist
  - ☐ Passive
- ☐ Neuromuscular Re-ed
- ☐ Gait Training
- ☐ Sport Specific Training
- ☐ Sport Rehabilitation
- ☐ Manual Therapy
  - ☐ Joint Mobilization
  - ☐ Myofascial Release
  - ☐ Soft Tissue Mobilization
- ☐ Post-Surgical Rehabilitation
- ☐ Modalities
  - ☐ E-Stim
  - ☐ Ultrasound
  - ☐ Hot Pack
  - ☐ Cryotherapy
  - ☐ Traction
    - ☐ Cervical
    - ☐ Lumbar
- ☐ Therapeutic Exercise
- ☐ Core/Lumbar Stabilization
- ☐ Posture Education
- ☐ Balance Training
- ☐ Other ______________

I certify that this therapy is medically necessary.
Please fax referrals to (432) 286-9250

PHYSICIAN SIGNATURE ______________ DATE ______________

4400 N. Big Spring St, Suite A-9, Midland, Texas 79705
Phone: (432) 360-2500 Fax: (432) 286-9250