



Patient Name: _____ Date: _____

Employer name if applicable: _____

Diagnosis: _____

Frequency / Duration _____ ICD-9 Code _____

Patient Follow-up Appointment: _____

- ____ Onsite Therapy Evaluation and Treatment
- ____ Work Conditioning Evaluation and Treatment
- ____ Work Capacity Evaluation
- ____ Post Offer Screen
- ____ Early Intervention Program (EIP)
- ____ Ergonomic Job Position Evaluation/Analysis (EJPE)
- ____ Job Analysis

TREATMENT:

Modalities:

- ____ Per Therapist Discretion
- ____ Heat
- ____ Ice/Cryotherapy
- ____ Ultrasound
- ____ Electrical Stimulation
- ____ TENS
- ____ Paraffin
- ____ Iontophoresis
- ____ Traction
- ____ Other _____

Therapeutic Exercise:

- ____ Per Therapist Discretion
- ____ Passive ROM
- ____ Active ROM
- ____ Strengthening Exercises
- ____ Stretching Exercises
- ____ Spinal Rehabilitation
- ____ Body mechanics/ADL's
- ____ Other _____

Manual Therapy:

- ____ Soft Tissue Mobilization
- ____ Stretching Exercises
- ____ Joint Mobilization
- ____ Massage
- ____ MFR ????
- ____ Other _____

I certify that the prescribed therapy is medically necessary for this patient's condition.

Physician Signature: _____ **Date:** _____

Please Print Physician Name: _____

Phone: _____ Fax: _____