OPTIMUMPHYSIO
THERAPIES

Patient Infos:

Name: _____ Phone #: _____
DOB: _____ Social Sec. #: _____
Insurance Name: _____ Insurance Phone #: _____
Member ID: _____ Group #: _____

Referred by:

Name :_____ NPI: _____
Phone #:_____ Contact name: _____
Diagnosis:_____ DiagnosisCode(s):_____
Surgery:_____ Precautions:_____

Referred for:

□ **Physical Therapy** **Frequency _____ Duration _____(wks/visits)**

□ **Home Health** □ **Per PT**

Evaluate & treat as indicated:

Therapeutic Exercise Activities

□ As indicated per P.T.
□ PROM/AAROM/AROM
□ Joint Mobilization
□ Strengthening
□ Stretching
□ Neuromuscular Re-ed
□ Proprioceptive Training
□ Gait Training
□ Other: _____

Manual Therapy

□ As indicated per P.T.
□ Soft Tissue Mobilization
□ Myofascial Release
□ Other: _____
_____

Modalities

□ As indicated per P.T.
□ Hot/Cold Pack
□ Ultrasound
□ E-Stim
□ Traction
□ Paraffin
□ Other: _____
_____
_____

I certify that the prescribed treatment is an appropriate course of and the services prescribed are medically necessary.

_____ _____
Physician Signature ***Date***

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