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Patient's Name:____

Patient's Phone #: ____

Diagnosis

❑ **Evaluate and Treat**

Goals:

❑ Improve Balance

❑ Improve Gait

❑ Increase Strength

❑ Increase ROM

❑ Decrease Pain

❑ Other:____________

Frequency/Duration:

❑ Therapist Discretion

❑ 2 x/week x ____ weeks

❑ 3 x/week x _____weeks

❑ _____ x/week x ____weeks

❑ 1 x – Home Exercise Program

Precautions/Specific Instructions: ____
____
____

Return to MD date: ______________

Physician's Signature: __________________________________ Date: ____________

This certifies Medical Necessity. Unless otherwise noted, therapist has discretion to reduce frequency as appropriate.