



# PARAMOUNT

PHYSICAL THERAPY & REHAB

www.ParaRehab.com

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Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Phone: \_\_\_\_\_ DOB: \_\_\_\_\_

Treating Doctor: \_\_\_\_\_ NPI No: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Fax Phone: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD-10 Code: \_\_\_\_\_

Reports to Doctor  Monthly Progress  Weekly Progress

<b>Physical Therapy:</b>	<b>Modalities:</b>	<b>Procedures:</b>
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- PT Evaluation & Treatment
- Vestibular Rehab
- CVA / Stroke Rehabilitation
- Pelvic Floor Eval & Treatment

- Electrical Stimulation
- Moist Heat / Cold Pack
- Paraffin Bath
- Ultrasound
- Cervical / Lumbar Traction
- Blood Flow Restriction (BFR)
- Dry Needling

- Gait Training
- Balance & Proprioception
- Manual Therapy / Myofascial Release
- Postural Re-Education
- ROM
- Therapeutic Exercises
- Neuromuscular Re-education

Frequency:

- Therapist Discretion     4X Week     3X Week     2X Week     1X Week

Duration:

- 1 Week     2 Week     3 Week     4 Week     6 Week     Other \_\_\_\_\_

### Statement of Medical Necessity:

I certify that the physical therapy is medically and therapeutically necessary, and they require skills of a licensed therapist.

- |          |   |  |   |                              |                                      |                                    |                                  |
|----------|---|--|---|------------------------------|--------------------------------------|------------------------------------|----------------------------------|
| Improve  | <input type="checkbox"/> Function                               | <input type="checkbox"/> Mobility                  | <input type="checkbox"/> Strength                   | <input type="checkbox"/> ROM | <input type="checkbox"/> Flexibility | <input type="checkbox"/> Endurance | <input type="checkbox"/> Posture |
| Decrease | <input type="checkbox"/> Pain                                   | <input type="checkbox"/> Musculoskeletal Tightness | <input type="checkbox"/> Functional Limitations     |                              |                                      |                                    |                                  |
| Promote  | <input type="checkbox"/> Ability to Return to Work (Light Duty) |  | <input type="checkbox"/> Health/Physical Well Being |                              |                                      |                                    |                                  |
|          | <input type="checkbox"/> Ability to Return Work (Full Duty)     |  | <input type="checkbox"/> Functional Mobility        |                              |                                      |                                    |                                  |

Physician's Signature: \_\_\_\_\_

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_