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

Physical Therapy:	Modalities:	Procedures:
❑ PT Evaluation & Treatment	❑ Electrical Stimulation	❑ Gait Training
❑ Vestibular Rehab	❑ Moist Heat / Cold Pack	❑ Balance & Proprioception
❑ CVA / Stroke Rehabilitation	❑ Paraffin Bath	❑ Manual Therapy / Myofascial Release
❑ Pelvic Floor Eval & Treatment	❑ Ultrasound	❑ Postural Re-Education
	❑ Cervical / Lumbar Traction	❑ ROM
	❑ Blood Flow Restriction (BFR)	❑ Therapeutic Exercises
	❑ Dry Needling	❑ 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 ❑ Function ❑ Mobility ❑ Strength ❑ ROM ❑ Flexibility ❑ Endurance ❑ Posture

Decrease ❑ Pain ❑ Musculoskeletal Tightness ❑ Functional Limitations

Promote ❑ Ability to Return to Work (Light Duty) ❑ Health/Physical Well Being

❑ Ability to Return Work (Full Duty) ❑ Functional Mobility

Physician's Signature: ______________________ Date ____ / ____ /____