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 ____ / ____ /____