ACCELERATED PHYSICAL THERAPY

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Tracy M. Law, MPT Alex Saratsiotis, MPT

Patient Name:_____ Date:_____

Physician:_____

Diagnosis:_____

Precautions:_____

☐ **Evaluate and Treat**

THERAPEUTIC EXERCISE

- ☐ AROM
- ☐ PROM
- ☐ Joint Mobilization
- ☐ Soft Tissue Mobilization
- ☐ Progressive Resistive Program
- ☐ Lumbar Program
- ☐ Endurance Training
- ☐ Gait Training
- ☐ Home Program
- ☐ McKenzie Program
- ☐ Balance Program

MODALITIES

- ☐ Ultrasound
- ☐ Electrical Stimulation
- ☐ Iontophoresis
- ☐ Traction
- ☐ Moist Heat/Cold Packs
- ☐ Contrast Bath
- ☐ TENS Unit

SPECIAL INSTRUCTIONS:

Frequency:_____/Week for _____ Weeks _____ As Needed

I hereby certify that these services are medically necessary for the patient's plan of care.

Physician's signature: _____