

Patient Name: _____

Diagnosis: _____

Frequency: _____ times a week for _____ weeks

PHYSICAL THERAPY **OCCUPATIONAL THERAPY** **SPEECH THERAPY**

EVALUATE PATIENT, ESTABLISH AND IMPLEMENT PLAN OF CARE

THERAPEUTIC EXERCISE/ACTIVITIES

MANUAL THERAPY

GAIT TRAINING

AQUA THERAPY

THERAPEUTIC MODALITIES

HOME EXERCISE PROGRAM

PRECAUTIONS: _____

SPECIAL INSTRUCTIONS: _____

Please ensure the following areas are complete:

Patient Name, Diagnosis, Frequency/Duration, Type of Therapy ordered and valid physician signature (rubber stamp not acceptable). Initiation of therapy services will begin after physician signs off on established plan of care or checks "Evaluate patient, establish and implement plan of care" box above.

I have examined the patient and certify the need for these services furnished under this plan of care effective and necessary. The patient will remain under my care and the above plan of care established will be reviewed minimally every 30 days.

Physician's Signature

Date