AMERICARE PHYSICAL THERAPY
MAXIMIZE YOUR BODY'S POTENTIAL

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Phone: 908-389-9100 | Fax: 908-389-9101

Patient Name: _____ Phone: _____

Diagnosis/Surgery: _____

Physician: _____

## ❑ Physical Therapy ❑ Occupational Therapy

### EVALUATE AND TREAT

**Modalities**

❑ Hot Pack ❑ Cold Pack ❑ Ultrasound ❑ Electrical Stimulation
❑ Iontophoresis ❑ Phonophoresis ❑ Massage/MFR ❑ Taping
❑ Modalities PRN: at PT's discretion

**Exercise**

❑ Active ROM ❑ Passive ROM ❑ Stretching ❑ Strengthening
❑ PRE's ❑ Mobilization ❑ Isometrics ❑ Conditioning
❑ Gait Training ❑ Home Program ❑ Other_____

**Program**

❑ Lumbar Stabilization ❑ Back School ❑ Splinting
❑ McKenzie Program ❑ LSVT-BIG ❑ Joint Replacement
❑ Concussion ❑ Lymphedema ❑ Pre/Post Rehab
❑ ACL, Post-OP Rehab ❑ Pelvic Floor ❑ Balance Program
❑ Post Mastectomy ❑ Annual Physical Fitness Check-Up ❑ TMJ/TMD
❑ Post-Op Shoulder Recovery ❑ Hand Therapy ❑ Structural Integration

### LENGTH OF TREATMENT

Frequency: _____(times per week)

Duration: _____(number of weeks)

PHYSICIAN COMMENTS: _____

_____

*My signature authorizes this treatment to be medically necessary*

_____ _____

Physician Signature Date