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REHABILITATION PRESCRIPTION/TREATMENT PLAN

❑ WORKER'S COMPENSATION TREATMENT PLAN ❑ PHYSICAL THERAPY
❑ NO-FAULT TREATMENT PLAN ❑ PRIVATE ❑ OTHER ❑ MASSAGE THERAPY

Patient's Name: ____________________

DOB: ____________________ Home Phone: ____________________

DIAGNOSIS: / ICD-9 ____________________

DOI: ____________________ Work Phone: ____________________

Precautions/Comments ____________________

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Insurance ____________________ Claim No. ____________________

Adjuster ____________________ Phone ____________________

FREQUENCY AND DURATION: ________ times per week for ________ weeks.

Total Treatments: ____________________

EVALUATIONS: ❑ Evaluate and Treat (with reevaluation every ____ days)
❑ Function Capacity Exam / Job Site Analysis

PHYSICAL REHABILITATION

- ____ Therapeutic Exercises/PRE
- ____ Spinal Stabilization Exercises
  - ____ Cervical
  - ____ Thoracic
  - ____ Lumbar
- ____ Neuromuscular Re-education
- ____ Gait Training
- ____ Home Exercise Program
- ____ Hand Therapy
- ____ Work Conditioning
- ____ Manual Therapy

PROCEDURES

- ____ ROM
  - ____ Active
  - ____ Passive
- ____ Joint Mobilization
- ____ Soft Tissue Mobilization
- ____ Myofascial Release
- ____ Splinting
- ____ Orthotics
- ____ Speech Therapy
- ____ Massage Therapy

MODALITIES

- ____ Ultrasound
- ____ Electric Muscle Stim.
- ____ Hot Pack/Cold Pack
- ____ Traction
  - ____ Cervical
  - ____ Pelvic
- ____ Iontophoresis
- ____ Phonophoresis
- ____ TENS
- ____ Paraffin

I certify the services furnished under this plan are reasonable and necessary.

Physician's Signature: ____________________ **M.D.**

Print Physician's Name: ____________________ **Date:** ____________

Begin Date ____________________ Projected Termination Date ____________________

Total Cost ____________________

Therapist's Signature ____________________ Date ____________________