THERAPY HOUSE CALLS
IN-HOME THERAPY & REHABILITATION SERVICES

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PHYSICAL THERAPY PRESCRIPTION

Patient Name:_____ DOB:_____

Patient Phone Number:_____Email:_____

Patient Address:_____ City:_____State: NY Zip:_____

Physician:_____ Follow Up Date:_____

Diagnosis/Past Medical History: _____

Precautions/Comments: _____

- ❑ Evaluate & Treat
- ❑ Therapeutic Exercise [97110]
  - ❑ Range of Motion
  - ❑ Stretching
  - ❑ Strengthening
- ❑ Manual Therapy/Joint Mobilization [97140]
- ❑ Neuromuscular Re-Education [97112]
- ❑ Balance Training/Vestibular Rehabilitation
- ❑ Gait Training [97116]
- ❑ Modalities
  - ❑ Hot/Cold Packs
  - ❑ Electrical Stimulation
  - ❑ Ultrasound
  - ❑ TENS
  - ❑ Cold Laser
- ❑ Home Exercise Program
- ❑ Home Safety Evaluation
- ❑ Fall Risk Assessment
- ❑ Home Equipment
  - ❑ Assessment/Recommendation
  - ❑ Modification/Training
- ❑ Orthotic [97760]/Prosthetic Training [97761]
- ❑ Self Care/Home Management Training [97535]
- ❑ Transfer Training
- ❑ Therapeutic Activities [97530]
- ❑ Goals:
  - ❑ Improve ROM
  - ❑ Improve Strength
  - ❑ Improve Mobility
  - ❑ Improve Function
  - ❑ Improve Balance
  - ❑ Other:_____

Frequency of Treatment:

Standard Treatment Plan: _____ times per week for _____ weeks.

I hereby certify that Physical Therapy is medically necessary for this patient's plan of care.

Physician's Signature:_____ NPI #:_____ Date:_____

Please fax this prescription to 631-448-4060. THANK YOU!