BPT

BEEVILLE PHYSICAL THERAPY

MEDPLEX Building
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PHYSICAL THERAPY PRESCRIPTION

Patient Name: _____ DOB: _____

Physician: _____

Diagnosis: _____

Comments: _____

- ☐ Evaluate & Treat
- ☐ Modalities
  - ☐ Hot/Cold Packs
  - ☐ Ultrasound
  - ☐ Electrical Stimulation
  - ☐ Paraffin
  - ☐ Vasopneumatic Device
  - ☐ Traction
- ☐ Other
- ☐ Therapeutic Exercise
- ☐ Neuromuscular Re-Education
- ☐ Gait Training
- ☐ Massage
- ☐ Manual Therapy
- ☐ Taping
- ☐ Postural Instruction
- ☐ Home Exercises
- ☐ Work Conditioning

Number of visits per week: *1* *2* *3* *4* *5*

Treatment duration: *1-4* *4-8* *8-12 weeks*

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

_____ _____

Signature *Date*