MARESCA PHYSICAL THERAPY

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☐ **In-Home Outpatient Therapy**

☐ **Clinic Based Outpatient Therapy**

___ New Order

Date: _____

Patient: _____

Phone: _____

Diagnosis: _____

___ Continuation Order

Physician: _____

DOI/DOS: _____

Insurance: _____

___ Physical Therapy Evaluation and Treatment

___ Times/Week for ___ Weeks

(Optional): ___ Treatment to Include the Following:

Therapeutic Procedures

___ Therapeutic Exercise/Activities
___ Manual Therapy
- Joint Mobilization
- Manual Traction
- Soft Tissue Mobilization/Myofacial Release

___ Gait Training
___ Neuromuscular Re-education
___ ADL Training
___ Other (please specify): _____
___ Issue the following Equipment: _____

Modalities

___ Cold Packs/Hot Packs
___ Ultrasound
___ Electric Stimulation
___ Traction
___ Issue Tens Unit

Physician's Signature _____ **Date** _____