IMPORTANT
Bring this prescription and any HMO referral, Auto or Worker's Comp authorizations on your first day.

Advanced Physical Therapy Center
The therapist you choose does make a difference

Grand Blanc (810) 695-8700
Fax (810) 695-7946
Clio (810) 687-8700
Fax (810) 687-8724
Flint (810) 732-8400
Fax (810) 732-4075
Hartland (810) 632-8700
Fax (810) 632-5850
Goodrich (810) 636-8700
Fax (810) 636-8702
Davison (810) 412-5100
Fax (810) 412-5106
Clarkston (248) 620-4260
Fax (248) 620-4239

❑ PRESCRIPTION

❑ ***MEDICARE CERTIFICATION/RECERTIFICATION***

Date_____Patient Phone Number_____

Name_____

Diagnosis_____

Precautions_____

Physical / Occupational / Hand Therapy

- ❑ **Evaluate and Treat per Care Plan**
- ❑ Home Exercise Program
- ❑ Self Care Education
- ❑ Therapeutic Exercise
  - ❑ Passive ROM
  - ❑ Active-assisted ROM
  - ❑ Active ROM
  - ❑ Progressive Resistive Exercise
- ❑ Sports Rehab
- ❑ Neuromuscular Re-Education
- ❑ Vestibular Rehab
- ❑ LSVT Big Therapy
- ❑ Gait and Balance Training
  WB Status:_____
- ❑ Advanced Stabilization
- ❑ Med X Testing/Rehab
- ❑ Pediatric Transformers Program
- ❑ Sportsmetrics
- ❑ Manual Techniques
- ❑ Graston Technique
- ❑ Joint Mobilization
- ❑ Myofascial Release
- ❑ Soft Tissue Massage
- ❑ Ultrasound/Phonophoresis
- ❑ Iontophoresis
- ❑ Light/Laser Therapy
- ❑ Electrical Stimulation
- ❑ Cervical Traction
- ❑ Pelvic Traction
- ❑ TENS
- ❑ Biofeedback
- ❑ Contrast Bath/Whirlpool
- ❑ Bioness
- ❑ Women's Health
- ❑ Paraffin Bath
- ❑ Fluidotherapy
- ❑ Pinch/Grip strengthening
- ❑ Scar massage
- ❑ Desensitization
- ❑ Orthotic Fabrication: _____
- ❑ Tendon Repair Protocol_____
- ❑ Therapeutic Activities
- ❑ ADL Activities_____
- ❑ TMJ Rehabilitation
- ❑ Lymphedema Treatment
- ❑ Functional Capacity Evaluation
  - ❑ Work Reconditioning/Hardening
  - ❑ Return to Work Assessment
  - ❑ Disability Testing
- ❑ Ergonomic Assessment

Comments/Goals_____

_____

❑ 3 x Weekly ❑ 2 x Weekly ❑ Daily **Number of visits**_____

for_____**weeks**_____**months**

I ❑ certify / ❑ recertify that I have examined the patient and physical and/or occupational therapy is necessary, and that services will be furnished while the patient is under my care, and that the plan is established and will be reviewed every ninety (90) days or more often if the patient's condition requires. I estimate that these services will be needed for 90 days.

℞ _____

Physician Signature Date

PHYSICAL AND OCCUPATIONAL THERAPY APPOINTMENT INFORMATION: When you receive this prescription please call to set up your first appointment. Bring this prescription, all insurance information such as insurance cards, forms, HMO referrals, worker's compensation or auto insurance claim numbers. Check with your insurance company if you are unsure of your physical and occupational therapy benefits. Wear or bring comfortable clothing so that the area to receive treatment can be easily exposed. Hospital gowns will be provided when needed. If it is necessary to cancel and reschedule, please try to notify us 1 day in advance.

We look forward to serving your rehabilitation needs.

For further information, you may contact us by phone or to speed your registration process, fill out / print forms online at **www.advancedphysicaltherapy.com** under **NEW PATIENTS**.