PARAMOUNT
PHYSICAL THERAPY & REHAB

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Houston, TX 77063
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FAX PRESCRIPTIONS TO (713) 270-5910
www.ParaRehab.com

Patient Name: _____ Date: _____

Home Phone: _____ Date of Birth: _____

Mobile Phone: _____ Email: _____

Treating Doctor: _____ NPI No: _____

Office Phone: _____ Fax Phone: _____

Diagnosis: _____ ICD-10 Code: _____

Reports to Doctor ❒ Monthly Progress ❒ Weekly Progress ❒ Other: _____

℞ Prescription for Physical Therapy

Physical Therapy:	Modalities:	Other Services:
❒ PT Evaluation Only	❒ Electrical Stimulation	❒ Dry Needling
❒ PT Evaluation & Treatment	❒ Moist Heat Pack	❒ Vestibular Rehab (Vertigo/BPPV)
❒ Manual Therapy	❒ Cold Pack	❒ Fall Risk Assessment & Prevention
❒ Balance & Proprioception Training	❒ Ultrasound	❒ Wheelchair / Scooter Assessment
❒ CVA / Stroke Rehabilitation	❒ Cervical Traction	❒ Functional Capacity Evaluation (FCE)
❒ Gait Training	❒ Lumbar Traction	❒ Work Conditioning
❒ Home Exercise Program		❒ Work Hardening

❒ Protocol_____ ❒ Other_____

Frequency:

❒ Therapist Discretion ❒ 4 X Week ❒ 3X Week ❒ 2X Week ❒ 1XWeek

Duration:

❒ 1 Week ❒ 2 Weeks ❒ 3 Weeks ❒ 4 Weeks ❒ 6 Weeks ❒ Other _____

Statement of Medical Necessity:

I certify that the physical therapy procedures prescribed for this patient are medically and therapeutically necessary, and they require skills of a licensed physical therapist to:

Improve ❒ Function ❒ Mobility ❒ Strength ❒ ROM ❒ Flexibility ❒ Endurance ❒ Posture

Decrease ❒ Pain ❒ Musculoskeletal Tightness ❒ Functional Limitations

Promote ❒ Ability to Return to Work (Light Duty) ❒ Health/Physical Well Being

❒ Ability to Return to Work (Full Duty) ❒ Functional Mobility

Physician's Signature: _____ Date: _____ /_____/_____