MARYSVILLE PHYSICAL THERAPY
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MARK RAMSEY PT, OCS, C.H.T. ANN-MARIE WALTERS, PT, CERT MDT
AMY MERRY, MHS, PT ANGELA LANDSETTLE, PT

NAME: _____ **DOB**: _____

DIAGNOSIS: _____

DATE/TYPE OF SURGERY: _____

ICD 10 CODE: _____

PRECAUTIONS/CONTRAINDICATIONS: _____

TREATMENT DURATION/FREQUENCY:

- Therapist's Discretion
- 1 2 3 4 5 visits per week for _____ weeks

TREATMENT:

- Evaluate and Treat
- Continue P.T.
- Modalities as Indicated
- Spine Clinic
  - ___McKenzie Assessment/ Treatment
  - ___Stabilization/Conditioning
- Headache Clinic
- Mom's Back Clinic
- Mechanical Home Traction Unit-Dispense & Instruct
- TENS Dispense & Instruct
- Isokinetic Exam
- Extremity Exercise
  - ___ Passive
  - ___ Active
  - ___ Resistive
- Cervical Traction
- Protocol
  - ___ Use MPT Protocol
  - ___ See Attached Protocol

- Orthotics/Bracing _____

- Other _____

I certify that this treatment is medically necessary for this patient's condition.

Physician's Signature: _____**Date:** _____

THANK YOU FOR YOUR REFERRAL!