



INFINITY PHYSICAL THERAPY

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Location:

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Patient Information:

Date: _____

Name: _____ DOB: _____

Diagnosis: _____

Physician Orders: _____ times per week for _____ weeks

Evaluate and Treat

Treatment Regimen:

- Active/Passive Range of Motion
- Exercise Program
- Gait Training
- Home Exercise Program
- Progressive Resistive Strengthening
- Joint Mobilization
- Orthotic Fitting/Training
- Posture/Positioning/Body Mechanics
- Back School
- Balance/Proprioceptive Training
- Patient Education
- Functional Capacity Evaluation
- Work Conditioning Program
- Work Simulation

Modalities and Procedures:

- Ultrasound
- Electric Stimulation
- Moist Heat
- Cold Packs
- Manual Therapy/Massage
- TENS
- TENS Fitting/Training
- Phonophoresis with

- Iontophoresis with

- Traction
- Home Traction Unit Fitting/Training

Other: _____

I hereby certify these services as medically necessary for the patient's plan of care.

Physician (Printed) _____

Physician Signature: _____ Date: _____

Phone: _____ Fax: _____

NPI #: _____

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