Physical Therapy Orders

Patient Name_____

Address_____

_____

Patient Phone_____**Cell**_____

Patient DOB_____

Insurance #1_____

Insurance #2_____

Diagnosis/ICD-10_____

Plan of Care Frequency/Duration_____

☐Therapeutic Activities	☐Postural Training
☐Therapeutic Exercise	☐LSVT BIG Training
☐Balance Training	☐OTAGO
☐Transfer Training	☐Patient/Caregiver Training
☐Gait Training	☐Wheelchair Mobility
☐Adaptive Equipment	☐Pain Management
☐Manual/Massage Therapy	☐Home Safety Assessment
☐ADL Management	☐Vestibular

Physician Name_____

Physician Signature_____**Date**_____

_I Confirm That These Services Are Medically Neccesary

Progressive Rehabilitation Solutions, LLC

In Home Physical Therapy for the Low Country's Aging Adult

Kristin Bevilacqua PT, DPT (LSVT and OTAGO Certified)

PRSathome@outlook.com

Ph: 843-637-0225

Fax: 843-589-1585