



91 Camden Street, Suite 307
Rockland, ME 04841
Phone (207) 593-6682
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Patient Name: _____

Date: _____

**If attaching a demographic sheet, please skip to area labeled "Functional Limitations"*

Diagnosis: _____

Date of Birth: _____ **Patient Phone:** _____

Patient Insurance:

- | | | |
|------------------------------------------|------------------------------------------------|--------------------------------------|
| <input type="checkbox"/> Medicare | <input type="checkbox"/> Anthem BC/BS | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Aetna | <input type="checkbox"/> United Healthcare | _____ |
| <input type="checkbox"/> Harvard Pilgrim | <input type="checkbox"/> Worker's Compensation | _____ |

Functional Limitations or Impairments

- | | | |
|----------------------------------------------------|-------------------------------------------------|--------------------------------------|
| <input type="checkbox"/> Pain | <input type="checkbox"/> Weakness | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> ADL/Work Deficits | <input type="checkbox"/> Mobility Deficits | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Contracture/Decreased ROM | <input type="checkbox"/> Balance Deficits/Falls | _____ |

Prescription/Recommendations

- Physical Therapy Evaluation and Treatment** (must be checked)
- Balance/Coordination Training
- Manual Therapy/Joint Mobilization/Manipulation
- Strengthening/Range of Motion
- Vestibular Rehabilitation
- Electrothermal Modalities _____
- Other _____

Frequency and Duration of Therapy

- Per Physical Therapist
- Other _____

I certify the need for these services furnished under this plan of treatment and while under my care.

Provider Name (Please print): _____

Provider Signature: _____

Provider Phone: _____