PETKOV BODYWORK THERAPY
MEDICARE OUTPATIENT PARTICIPATING PROVIDER

Patient Name:_____________________ Patient DOB:______________Patient Phone #:______________

Diagnosis:____CPT code:______________________

Treatment Plan:
- At -Home Therapy
- Evaluate & Treat
- Continue Plan of Care

Exercise:
- Home Exercise Program
- Balance Training
- PROM/AROM / AAROM
- ADL/IADL Training
- Strength Training

Manual Therapy:
- Myofascial Release
- Neuromuscular Massage
- Joint Mobilization

Modalities:
- Heat Pack
- Cold Pack
- TENS
- Infrared Laser

Special Programs:
- ACL Protocol
- RTC Protocol
- Joint Replacement
- Arthritis Program
- Fall Prevention Program
- Other:____________

Frequency: 1x , 2x, 3x, 4x, 5x per week for: _____ weeks.

Special Instructions/ROM Restrictions/Precautions:

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REFERRING PROVIDER NAME (Please Print)

________________________ ______________________

SIGNATURE DATE

CERTIFICATE OF MEDICAL NECESSITY: I certify, recertify that I have examined the patient & physical is necessary & services will be furnished while the patient is under my care & that the plan is established & will be reviewed every 30 (thirty) days or more if the patient's condition requires.

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