EMPOWER PHYSICAL THERAPY

Outpatient PT in the home * No homebound requirement
Phone: (406) 283-1616
www.myempowerpt.com
Medicare participating provider

Patient Name:_____ Phone:_____

Provider: _____ Dx: _____

Comments:_____

Precautions/Special Instructions: _____

Treatment Plan
- ❑ Evaluate and Treat
- ❑ Continue Plan of Care

Manual Therapy
- ❑ Joint Mobilization
- ❑ Soft Tissue Mobilization
- ❑ Manual Traction
- ❑ Massage

Special Programs
- ❑ Balance / Falls
- ❑ Home Safety Evaluation
- ❑ Vestibular Rehabilitation
- ❑ Total Hip Replacement
- ❑ Total Knee Replacement
- ❑ Pain Management

Exercises
- ❑ Stretching
- ❑ Range of Motion
- ❑ Strengthening
- ❑ Gait Training
- ❑ Home Exercise Program
- ❑ Lumbar Stabilization
- ❑ Therapeutic activities

Modalities
- ❑ Ice
- ❑ Heat
- ❑ TENS
- ❑ Taping
- ❑ Ultrasound
- ❑ NMES

Frequency & Duration: _____ x / week for 1-4 5-8 9-12 weeks

I certify that physical therapy is medically necessary.

Provider Signature Date

Physical Therapy, delivered - Fax referrals to (406) 272-1640