



14 Second Street
Farmingdale, ME 04344
Office: 207-582-9898
Fax: 207-582-9899
www.kennebecpt.com

Patient:

Diagnosis:



EVALUATE AND TREAT

- | | |
|---|--|
| <input type="checkbox"/> ROM | <input type="checkbox"/> Modalities per Therapist Discretion |
| <input type="checkbox"/> Strengthening | <input type="checkbox"/> Ultrasound |
| <input type="checkbox"/> Spinal Stabilization | <input type="checkbox"/> E-Stim |
| <input type="checkbox"/> HEP Instruction | <input type="checkbox"/> Iontophoresis with 2.5 cc Dexamethasone |
| <input type="checkbox"/> Joint Mobilization | <input type="checkbox"/> Phonophoresis |
| <input type="checkbox"/> Soft Tissue Mobilization | <input type="checkbox"/> Manual Therapy Techniques |
| <input type="checkbox"/> McKenzie | <input type="checkbox"/> TENS |
| <input type="checkbox"/> Cervical Lumbar Traction | <input type="checkbox"/> Other |
| <input type="checkbox"/> Gait Training | |

Frequency/Duration _____ Times Per Week X _____ Weeks

Instructions/ Precautions:

I hereby certify the above treatment as medically necessary for the patient's plan of care.

Physician's Signature:

Date:

DO NOT EMAIL PRESCRIPTION The electronic prescription form is provided for your convenience. With respect to responding to this form, please do not send the prescription via email. Please populate, print and sign a hardcopy that may be faxed, mailed or hand delivered to the clinic.



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