



ESTERSON & ASSOCIATES

PHYSICAL THERAPY, P.A.

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www.EstersonTherapy.com

Rx PHYSICAL THERAPY

Patient's Name _____ Date _____

Dx: _____

Area/Part To Be Treated: _____

Precautions: _____ WB Status: _____

Evaluate and treat as appropriate

Frequency 1 2 3 4 5 / week Duration _____ weeks

I hereby certify that these services are medically necessary for the patient's plan of care.

Physician's Signature _____

NPI # _____ Email or fax # of referring physician: _____

TREATMENT PROCEDURES:

- | | |
|---|--|
| <input type="checkbox"/> Mechanical Traction | <input type="checkbox"/> Therapeutic Exercise |
| <input type="checkbox"/> Cervical | <input type="checkbox"/> Passive |
| <input type="checkbox"/> Lumbar | <input type="checkbox"/> Active |
| <input type="checkbox"/> Hot/Cold Packs | <input type="checkbox"/> Resistive |
| <input type="checkbox"/> Ultrasound | <input type="checkbox"/> Manual Therapy |
| <input type="checkbox"/> Electrical Stimulation | <input type="checkbox"/> Gait Training |
| <input type="checkbox"/> Paraffin Bath | <input type="checkbox"/> Isokinetic Testing |
| <input type="checkbox"/> Intermittent Compression | <input type="checkbox"/> Joint Mobilization |
| <input type="checkbox"/> Iontophoresis | <input type="checkbox"/> Massage/Soft Tissue Work |
| <input type="checkbox"/> Home Exercise Program | <input type="checkbox"/> Vertigo Treatment |
| <input type="checkbox"/> Myofascial Release | <input type="checkbox"/> Balance & Coordination Training |
| <input type="checkbox"/> Desensitization | <input type="checkbox"/> TMJ Program |
| <input type="checkbox"/> Work Hardening Program | <input type="checkbox"/> Other: _____ |

Doctor: Please check here if more referral pads are needed

DIRECTIONS FROM THE BELTWAY: Exit 17 Security Boulevard towards Rolling Road. After three traffic lights turn left on Rolling Road. Pass three short traffic lights and see our building complex on your left. We are in the West Building. Look for the large **PHYSICAL THERAPY** sign over our entry doors.