



APEX Physical Rehabilitation and Wellness

- MEMORIAL: 7575 San Felipe, Suite 125 • Houston, TX 77063 • Phone: (713) 270-5900
- SUGAR LAND: 4610 Sweetwater Blvd, Suite 120 • Sugar Land, TX 77479 • Phone: (281) 242-5252
- KATY: 777 S. Fry Rd, Suite 104 • Katy, TX 77450 • Phone: (713) 270-5900

FAX ALL PRESCRIPTIONS TO (713) 270-5910

www.ApexRehab.com

Patient Name: _____		Date: _____	
Home Phone: _____		Work Phone: _____	
Mobile Phone: _____		Email: _____	
Treating Doctor: _____		UPIN No: _____	
Office Phone: _____		Fax Phone: _____	
Diagnosis: _____		ICD-9 Code: _____	
Reports to Doctor: <input type="checkbox"/> Monthly Progress <input type="checkbox"/> Weekly Progress <input type="checkbox"/> Other: _____			

℞ Prescription for Physical Therapy

Physical Therapy:	Modalities:	Other Services:
<input type="checkbox"/> PT Evaluation Only <input type="checkbox"/> PT Evaluation and Treatment <input type="checkbox"/> Wheelchair Assessment <input type="checkbox"/> Cervical Traction <input type="checkbox"/> Lumbar Traction <input type="checkbox"/> Gait Training <input type="checkbox"/> Home Exercise	<input type="checkbox"/> Moist Heat Pack(s) <input type="checkbox"/> Cold Pack <input type="checkbox"/> Electrical Stimulation <input type="checkbox"/> Proprioceptive Neuromuscular Facilitation (PNF) <input type="checkbox"/> Therapeutic Exercise <input type="checkbox"/> PRE <input type="checkbox"/> ARROM <input type="checkbox"/> AROM <input type="checkbox"/> PROM <input type="checkbox"/> Neuromuscular Re-education <input type="checkbox"/> Transcutaneous Electrical Nerve Stimulation (TENS) <input type="checkbox"/> Iontophoresis/Phonophoresis <input type="checkbox"/> Ultrasound <input type="checkbox"/> Manual Therapy	<input type="checkbox"/> Aquatic Therapy <input type="checkbox"/> Spinal Decompression Program <input type="checkbox"/> Vestibular Rehab Therapy (VRT) <input type="checkbox"/> Fall Risk Assessment and Prevention <input type="checkbox"/> Balance and Proprioception Testing and Training <input type="checkbox"/> Functional Capacity Evaluation (FCE/DAE) <input type="checkbox"/> Impairment Rating <input type="checkbox"/> Work Conditioning <input type="checkbox"/> Work Hardening <input type="checkbox"/> Protocol: _____ <input type="checkbox"/> Other: _____

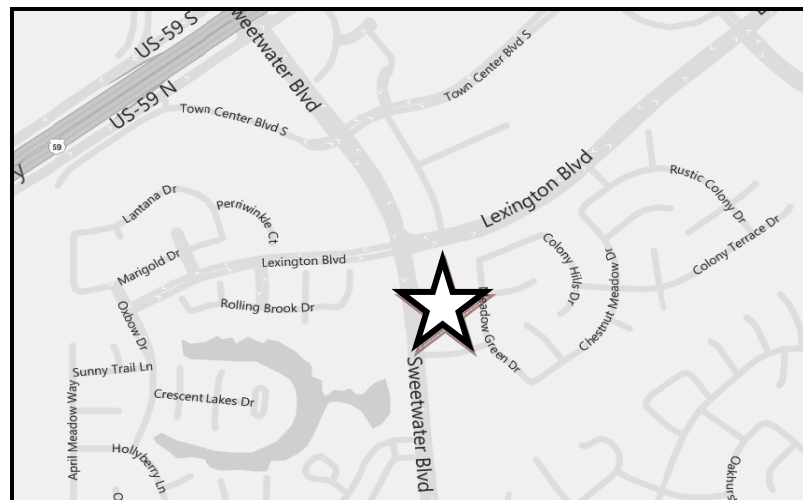
Frequency:				
<input type="checkbox"/> Therapist Discretion	<input type="checkbox"/> 5X Week	<input type="checkbox"/> 3X Week	<input type="checkbox"/> 2X Week	<input type="checkbox"/> 1X Week
Duration:				
<input type="checkbox"/> 8 Weeks	<input type="checkbox"/> 6 Weeks	<input type="checkbox"/> 4 Weeks	<input type="checkbox"/> 3 Weeks	<input type="checkbox"/> 2 Weeks
<input type="checkbox"/> Other: _____				

Statement of Medical Necessity:							
I certify that the physical therapy procedures prescribed for this patient are medically and therapeutically necessary, and they require skills of a licensed physical therapist to:							
Improve:	<input type="checkbox"/> Function	<input type="checkbox"/> Mobility	<input type="checkbox"/> Strength	<input type="checkbox"/> ROM	<input type="checkbox"/> Flexibility	<input type="checkbox"/> Endurance	<input type="checkbox"/> Posture
Decrease:	<input type="checkbox"/> Pain	<input type="checkbox"/> Musculoskeletal Tightness	<input type="checkbox"/> Functional Limitations				
Promote:	<input type="checkbox"/> Ability to Return to Work (Light Duty)		<input type="checkbox"/> Health/Physical Well Being				
	<input type="checkbox"/> Ability to Return to Work (Full Duty)		<input type="checkbox"/> Functional Mobility				
Physician's Signature _____						Date: ____/____/____	

MEMORIAL (Corporate Office)
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