

CAMPBELL PHYSICAL THERAPY & SPORTSCARE

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**DS PHYSICAL THERAPY AND SPORTSCARE**

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 PRIVATE

PATIENT _____ DATE _____

 INDUSTRIAL

DIAGNOSIS _____

 MEDICARE AUTO**PREFERRED PROVIDERS**

DATE OF SURGERY/INJURY _____ NEXT DOCTOR'S APPT _____

 Aetna Health Plans**EVALUATE AND TREAT** Blue Cross**Treatment Plan****Treatment Goals** Blue Shield Manual Therapy Decrease Pain Cigna Therapeutic Exercise Increase Range of Motion Community Care
Network (CCN) Joint Mobilization Increase Strength First Health Traction Increase Endurance HealthNet PPO Ultrasound Improve ADL Function Great West Healthcare Low-Level Laser Increase Balance and Coordination Interplan Electrotherapy Improve Posture Multiplan Whirlpool Pacificare PPO Gait Training Private Healthcare
Systems (PHCS)**GOALS AND SPECIAL INSTRUCTIONS** Santa Clara Foundation
for Medical Care

 United HealthCare**TREATMENT FREQUENCY/DURATION**
 DAILY
 4x/wk
 3x/wk
 2x/wk
 1x/wk
 PRN
 _____ # of weeks

Please call to inquire about
other PPO and HMO plans.

DOCTOR'S SIGNATURE _____

I certify/re-certify that I have examined the patient, that physical therapy is medically necessary and that service will be furnished while the patient is under my care, and the plan is established and will be reviewed every 30 days, or more often if the patient condition requires.