



Home Therapy, LLC

1730 Central park Ave. Ste 3, Yonkers, NY 10710

PHYSICAL THERAPY
OCCUPATIONAL THERAPY

Name: _____

PT

Diagnosis: _____

OT

Medical Precautions: _____

Frequency: 1 2 3 4 5 Times/Week _____ Weeks _____ As Needed

Evaluate and Treat

ADL Training / Assistive Aids

- Contrast Bath
- Cryotherapy
- Desensitization
- Edema Control
- Functional Electrical Stim.
- Gait Training
- HEP
- Ionto/Phonophoresis
- Joint Mobilization
- Stabilization Program
- Therapeutic Massage
- Moist Heat
- Prosthetic Training
- Range of Motion
- Therapeutic Exercise

Splint

BALANCE & VESTIBULAR REHAB

- Fall Risk Evaluation / Conditioning
- Balance Program
- Vestibular Rehabilitation
- Posture, Positioning, Body Mechanics
- Scar Massage
- TENS
- Therapeutic Activities
- Traction
- Ultrasound
- Work Hardening

1.914-573-6883

Fax: 1-914-623-048

Holsmanhealthcare.com

Restrictions/Instructions/Other: _____

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

Provider's Name (Please Print) _____

Provider's Signature _____ Date ___ / ___ / _____