1070 Clifton Ave Suite 1A Clifton, NJ 07013

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

1.973-246-6565
1-973-415-2306
Fax: 973-883-0140
www.holsmanPT.com
PHYSICAL THERAPIST
OWNED AND OPERATED

*Restrictions/Instructions/Other:*_______________________________
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I hereby certify these services as medically necessary for the patient's plan of care.

Provider's Name (Please Print)____

Provider's Signature__________________________________ Date ___ /___ /________

- Early AM & Late PM Hours Available
- New Patient Appointments Offered Within 24 Hours
- Patient Transportation Services Available