



Evidence Based Challenging Effective

IN-HOME PHYSICAL THERAPY FOR A RANGE OF CONDITIONS AND AGES

SPECIALIZED SERVICES

IN-HOME GERIATRIC PHYSICAL THERAPY

- ▶ IN-HOME FALL PREVENTION PROGRAM
- ▶ IN-HOME BALANCE IMPROVEMENT PROGRAM
- ▶ IN-HOME OSTEOPOROSIS PROGRAM
- ▶ IN-HOME MOBILITY, SAFETY, AND EQUIPMENT ASSESSMENT

SERVING

GREATER SAINT LOUIS METRO AREA

314-558-1385
314-558-2600 (fax)
www.mobile-pt.com

Member of
American Physical Therapy Association
Missouri Physical Therapy Association
Geriatric Section of the APTA
Home Health Section of the APTA

Physical Therapist Owned and Operated

*Medicare Part B, Private Pay, and Out-of Network providers for most insurances.

MOBILE PHYSICAL THERAPY

Brad Abrams PT, DPT

Name: _____

Diagnosis: _____

Precautions and Goals: _____

Frequency: ___ until goals met
___ to be determined at evaluation
___x week for ___ weeks

Programs, Procedures and Modalities

Evaluate and Treat

Balance Program Osteoporosis Program

Fall Prevention Program Mobility, Safety, and Equipment Evaluation

- Therapeutic Exercise (**Strengthening, ROM, Flexibility**)
- Neuromuscular Reeducation (**Balance, Coordination, Proprioception**)
- Gait Training** (including Stair Climbing)
- Manual Therapy** (Joint Mobilization, etc.)
- Therapeutic Activities** (dynamic/functional activities)
- Development of Cognitive Skills** (Memory, Attention, Problem Solving)
- Self-Care and Home Management**
- Community and Work Integration**
- Home Exercise Program**
- Create Video of Home Program**
- Modalities: (circle) Moist Heat Cryotherapy Electrical Stim Ultrasound Other: _____**
- Therapeutic Taping** (McConnell Kinesiotaping)

OTHER: _____

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

Provider's Signature: _____

Provider's Name: (PRINT) _____

Date ___/___/___ **Provider's Phone:** _____

*****PLEASE INCLUDE PATIENT CONTACT AND INSURANCE INFO*****

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