www.procarebetter.com

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☐ **PINECROFT**
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Altoona , PA 16602
P: (814) 631-9520 F: (814) 631-9521

☐ **ROARING SPRING**
7448 Woodbury Pike
Roaring Spring, PA 16673
P: (814) 224-5566 F: (814) 224-2474

☐ **TYRONE**
154 Hospital Dr, Suite B
Tyrone, PA 16686
P: (814) 684-2133 F: (814) 684-2188

Patient Name: ______________________________ Date: ______________________

Diagnosis: ____

Frequency/Duration: ______ x's per week for ______ weeks

LEVEL I ACUTE	☐ Evaluation ☐ Evaluation and Treatment ☐ Modalities of Choice ☐ Manual Muscle Testing ☐ Therapeutic Exercise ☐ Moist Heat ☐ Ultrasound	☐ Phonophoresis ☐ Intophoresis ☐ Electrical Stimulation ☐ Whirlpool ☐ Paraffin ☐ Massage ☐ Cryotherapy	☐ TENS ☐ Joint Mobilization ☐ Myofascial Release ☐ Other: ______________ ______________
LEVEL II SUBACUTE	☐ Therapeutic Exercise ☐ Home Exercise Program		
LEVEL II & IV PHYSICAL CONDITIONING	☐ FCE (Functional Capacity Evaluation) ☐ Work Conditioning ☐ Work Hardening ☐ On Site Job Analysis		
LEVEL V WORKSITE	☐ On Site Work Conditioning/ Work Hardening		

Special Instructions: ____

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I hereby certify that the above services have been deemed medically necessary.

Provider Signature: ______________________________ Date: ______________________

Print Name: ____

DO NOT EMAIL PRESCRIPTION The electronic prescription form is provided for your convenience. With respect to responding to this form, please do not send the prescription via email. Please populate, print and sign a hardcopy that may be faxed, mailed or hand delivered to the clinic.