Recovery Waters
PHYSICAL THERAPY

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Patient Name: _____ Date of Birth: _____

Physician's Name: _____

Diagnosis: _____

Precautions/Comments: _____

☐ PHYSICAL THERAPY

- o **Evaluate and Treat**
- o Lymphedema Treatment
- o Compression Garment Fitting
- o Pneumatic Compression Pump Assessment
- o Skin and Nail Care Training
- o Lipedema Treatment
- o Manual Lymphatic Drainage
- o Balance Training
- o Gait Training
- o Strengthening
- o Range of Motion
- o Postural Training
- o Home Program

☐ MASSAGE THERAPY

- o Manual lymphatic drainage
- o Post-operative massage
- o Soft Tissue Mobilization/Massage
- o Myofascial Release
- o Kinesio Tape
- o Structural Integration
- o Graston Technique

I hereby certify that the above marked medical care is medically necessary for this patient's plan of care.

Number of visits per week: 1 2 3 4 5

Treatment Duration _____ weeks

Signature Date