

626 Trail Avenue, Frederick, MD 21701

301-662-1997/ Fax: 301-668-2202

**Physical Therapy Letter of Medical Necessity**

Therapist Name, license #

**Patient name:**

**Recommended Equipment:**

Rolling walker / Rollator

**Therapy Justification:**

This patient presents with unsteady gait and requires assistance for transfers and ambulation.  S/He demonstrates good potential with hand held ambulation for more stable gait with the use of a rolling walker.  A rolling walker would afford him/ her increased stability providing for more frequent ambulation which will provide numerous benefits including but not limited to weight bearing, decreased dependency, increased pressure relief  and improved interaction with his environment.

Thank you for your time and consideration in this matter. Feel free to call with any questions of additional information which may be required. My cell is \*\*\*\*\*\*\*\*\*\*.

**Therapist signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physician signature:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_