

prescription

Patient Name _____ Date of Birth _____ Phone Number _____

Insurance Provider _____ Insurance ID _____

Diagnosis _____ ICD 10 CODE _____

Date of Injury _____ Date of Surgery _____

- Therapist evaluate and determine use of procedures, modalities, and / or frequency of treatment
- Precautions _____

PHYSICAL THERAPY PROCEDURES

ROM/ Strength/ Function
Manual Therapy
Gait/ Balance
Education (ergonomics/ posture) Home Exercise
ADL Retraining
Splint/ Orthotics _____

SPECIAL PROGRAMS

Vestibular Rehab
Balance Retraining
Home Safety Evaluation
Fall Risk Reduction
Pelvic Health/Incontinence/Pelvic Pain
Alter G Anti-Gravity Treadmill
Work Conditioning

MASSAGE THERAPY

Treatment Frequency _____ x-per week or _____ weeks, or _____ PRN
Physician Recheck Date _____

Physician Signature _____ Date _____

Physician Name _____ Physician Phone _____

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