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Prescription for Physical Therapy

Patient's Name: _____
Diagnosis: _____
Physician's Name: _____
Frequency: _____ Duration: _____

Prescribed Treatment

_____ Evaluate and Treat

HEAT:
Hydrocollator Packs..... _____
Ultrasound..... _____
Phonophoresis..... _____
Paraffin..... _____

CRYOTHERAPY:
Cold Laser..... _____
Ice Massage..... _____
Cold Packs..... _____

MANUAL THERAPY:
Joint Mobilization..... _____
Manual Stretching..... _____

Soft Tissue Mobilization..... _____

MECHANICAL TRACTION:
Cervical..... _____
Lumbar..... _____

ELECTOTHERAPY:
Electrical Stimulation..... _____
Iontophoresis..... _____
TENS..... _____

THERAPUTIC EXERCISES:
Active ROM Exer..... _____
Active-Assist Exer..... _____
Passive ROM Exer..... _____
Aerobic Exer..... _____
Resistance Exer..... _____
Sports-specific Training..... _____
Low Back Program..... _____
a) Core Stabilization..... _____
b) McKenzie Extension..... _____
c) Williams Flexion..... _____

Gait Training..... _____
Balance Training..... _____
Postural Re-education..... _____
Blood Flow Restriction Training..... _____
LVST Big Program..... _____

TREATMENT AREA:
Cervical..... _____
Thoracic..... _____
Lumbar..... _____
Rt. Shoulder/Elbow/Hand..... _____
Rt. Hip/Knee/Ankle/Foot..... _____
Lt. Shoulder/Elbow/Hand..... _____
Lt. Hip/Knee/Ankle..... _____

REHAB POTENTIAL: Excellent_____ Good_____ Fair_____ Guarded_____

I certify that I have examined this patient and have determined that Physical Therapy treatments are medically necessary.

Signature: _____ M.D. Date: _____