

Physical Therapy Prescription

Patient Name: _____

DOB: _____

Patient's phone #: _____

Diagnosis: _____

Special Considerations: _____

EVALUATE and TREAT

Other (please specify): _____

Specialty Rehab Programs/Procedures:

Schroth scoliosis program Other _____

Manual therapy Dry Needling

Sportsmetrics prehab or return to sport

Treatment Frequency:

Therapist discretion Other _____

Next MD Visit: _____

Physician signature

Date

Physician name (printed)

Physician #

Please fax this prescription to Lagniappe PT & Pilates @318-302-0140.

Check if more referral pads are needed.