

PHYSICAL THERAPY PRESCRIPTION

Patient Name: _____

Diagnosis: _____ Surgery: _____

Precautions/Contraindications: _____

REFERRAL FOR THERAPEUTIC SERVICES

- Evaluate and Treat
- P.A.T.
- Golf Program
- Throwers Program
- Ergonomic Evaluation
- Home Program

MODALITIES/PROCEDURES:

Modalities as Needed

- Cryotherapy
- Hot Pack
- Paraffin
- Phonophoresis/Iontophoresis
- TENS, EGS, IF, FES
- Traction: Mechanical/Manual
- Ultrasound
- Whirlpool
- Other: _____

THERAPEUTIC EXERCISES:

- Crutch/Gait Training
- Flexibility Training
- Resisted Strength Training
- ROM - Active, Passive, Assisted
- Spinal Stabilization

MANUAL THERAPY:

- Joint Mobilization
- Neural Tension Mobilization
- Soft Tissue Mobilization/Massage
- Taping Techniques
- Other: _____

Hand Evaluation

- ADL Assessment/Training
- Adaptive Equipment
- Desensitization
- Joint/Tendon/Muscle Protection
- Kinesio Taping
- Scar Modification/Conformer
- Splinting as needed
- Wound Care
- Other: _____

Frequency: _____ times a week for _____ weeks. Return to MD on: _____

Physician's Signature: _____

Date: _____