Outpatient Physical Therapy Rx

Date_____

Referring Physician Name_____ Phone #_____

Patient Name_____ DOB_____

Patient Cell Phone # _____

Diagnosis_____

Comments / Precautions_____

_____

Prescription:

☐Physical Therapy ☐Evaluate & determine modalities, treatments & frequency of treatments

Therapeutic Exercise

- ☐Active-Assisted ROM
- ☐Active / Resistance
- ☐ Isometric
- ☐ Core Strengthening
- ☐ Postural Exercises
- ☐ Scapular Stabilization
- ☐ Aerobic Conditioning
- ☐ Gait Training
- ☐ Balance Training

Manual Therapy

- ☐ Traction
- ☐ Joint Mobilization / Manipulation
- ☐ MFR
- ☐ Stretching
- ☐ Passive ROM

☐Pre-op Education & Therapy

☐Post-op Physician Specific Protocol

(please include protocol in fax)

Modalities

- ☐ Ultrasound
- ☐ Phono / Iontophoresis
- ☐ TENS / IFC
- ☐ Muscle Stim
- ☐ Taping
- ☐Mech. Traction

☐ Trigger Point Dry Needling

☐ McKenzie Assessment

Frequency / Duration: _____ time(s) per week for _____ weeks

_____

Physician Signature

Phone: (512) 569-7309
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