

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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Barkley

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Cordata

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