

# PRESCRIPTION FOR PHYSICAL THERAPY

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PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

DIAGNOSIS AND ICD-9 CODE: \_\_\_\_\_

FREQUENCY: (CHECK OR INDICATE)

- 1X/WEEK
- 2X/WEEK
- PRN
- OTHER \_\_\_\_\_

DURATION: (CHECK AND INDICATE)

- \_\_\_\_\_ WEEK(S)
- \_\_\_\_\_ MONTH(S)
- \_\_\_\_\_ YEAR
- PRN

SPECIFIC ORDERS:

- EVALUATE AND TREAT PER THERAPIST DISCRETION** (preferred)
- PHYSICAL THERAPY EVALUATION
- MANUAL THERAPY (PER THERAPIST DISCRETION)
  - SOFT TISSUE MOBILIZATION
  - JOINT MOBILIZATION GRADE I-V
- THERAPEUTIC EXERCISE (PER THERAPIST DISCRETION)
  - AROM
  - PROM
  - PREs
- BALANCE/PROPRIOCEPTIVE TRAINING
- HOME EXERCISE PROGRAM

SPECIAL INSTRUCTIONS/PRECAUTIONS: \_\_\_\_\_

\_\_\_\_\_

APPROVED MEDICAL PROVIDER SIGNATURE

DATE