Center for Integrated Health, LLC

PRESCRIPTION FOR PHYSICAL THERAPY

TRISHA A. BECKER, PT, DPT, MHS, OCS

PATIENT NAME: _____DOB:_____

DIAGNOSIS AND ICD-9 CODE: _____

FREQUENCY: (CHECK OR INDICATE)

- ☐ 1X/WEEK
- ☐ 2X/WEEK
- ☐ 1X/MONTH
- ☐ OTHER_____

DURATION: (CHECK AND INDICATE)

- ☐ _____WEEK(S)
- ☐ _____MONTH(S)
- ☐ _____YEAR
- ☐ _____OTHER

SPECIFIC ORDERS:

☐ **EVALUATE AND TREAT PER THERAPIST DISCRETION**

☐ PHYSICAL THERAPY EVALUATION

☐ MANUAL THERAPY (PER THERAPIST DISCRETION)

- ☐ SOFT TISSUE MOBILIZATION
- ☐ JOINT MOBILIZATION GRADE I-V

☐ THERAPEUTIC EXERCISE (PER THERAPIST DISCRETION)

- ☐ AROM/PROM
- ☐ CONCENTRIC
- ☐ ECCENTRIC

☐ BALANCE/PROPRIOCEPTIVE TRAINING

☐ HOME EXERCISE PROGRAM

SPECIAL INSTRUCTIONS/PRECAUTIONS:

_____

_____

_____

APPROVED MEDICAL PROVIDER SIGNATURE DATE

130 S. Bemiston Avenue, Suite 404 Clayton, MO 63105 ph: (314) 727-8887 fax: (314) 727-8893