THERAPY PRESCRIPTION

Patient Name: ___________________________ Date: ___________________________

Diagnosis: ___________________________ ICD-9 Code: ___________________________

___ Physical Therapy ___ Occupational Therapy ___ Speech Therapy

___ EVALUATE AND TREAT ___

___ Therapeutic Exercise ___
___ AROM ___
___ PROM ___
___ Strengthening/Endurance ___
___ Home Exercise Program ___
___ Lumbar Stabilization ___
___ Functional Training ___
___ Gait ___
___ Neuromuscular Re-education ___
___ Posture/Body Mechanics ___
___ ADLs/Work-Related Tasks ___
___ Therapeutic/Functional Activities ___
___ Sports Specific Skills ___
___ Cane/Crutch Training ___
___ Manual Therapy ___
___ Massage ___
___ Joint Mobilization ___
___ Desensitization/Nerve Glides ___

Restrictions: ___ Non Weight Bearing ___ Partial Weight Bearing ___ Full Weight Bearing

Special Instructions: ___________________________

Frequency: ______ x/week Duration: ______ weeks

Physician’s Signature: ___________________________ Date: ___________________________

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Modalities

___ At Therapist’s Discretion ___
___ Electrical Stimulation ___
___ Ultrasound ___
___ Moist Heat/Cold Packs ___
___ Aqua Therapy ___
___ Fluidotherapy ___
___ Traction ___
___ Lumbar ___ Cervical ___ Home Unit ___
___ Iontophoresis (4% Dexamethasone) ___

Positioning

___ Foot Orthotics ___
___ Bracing ___
___ Splinting ___
___ Wheelchair ___
___ Hand Therapy ___

Speech Therapy

___ Speech/Communication ___
___ Swallow TX ___

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