



PROFESSIONAL THERAPEUTIC HEALTH CARE

3618 LANTANA RD, SUITE 202

LAKE WORTH, FL 33462

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THERAPY PRESCRIPTION

PATIENT INFO

Name: _____

DOB: _____

Diagnosis: _____

Phone: _____

Precautions: _____

Insurance: _____

FREQUENCY

Therapy: PT ____ OT ____ SP ____ Frequency/Duration ____ Times/Wk ____ Wks

EVALUATION

☐ Evaluate for skilled therapy services and treat as necessary

TREATMENT PROCEDURES

☐ Functional Task Training

☐ Therapeutic Exercise

☐ Passive

☐ Active

☐ Active Assistance

☐ Resistive

☐ Muscle Stretching

☐ Gait Training

☐ Neuromuscular Re-Education

☐ Vestibular and Balance Rehabilitation

☐ Mammal Lymph Drainage

☐ Massage/Soft Tissue Mobilization

☐ Myofascial Release

☐ Manual Traction

☐ Joint Mobilization

☐ Hot/Cold Packs

☐ Ultrasound

☐ Electrical Stimulation

PROTOCOLS

☐ Please check if you would like to provide your own

☐ ACL Protocol

☐ Rotator Cuff Repair Protocol

☐ Total Hip Protocol

☐ Total Knee Protocol

☐ Total Shoulder Protocol

☐ McKenzie Extension

☐ Weight Bearing Restrictions: _____

Comments/Concerns: _____

Physician Signature: _____ Date: _____

Physician Name: _____