PATIENT PRESCRIPTION

PRESCRIPTION FOR: ☐ Physical Therapy ☐ Occupational Therapy ☐ Bio-feedback

☐ Epidural Steroid Series ☐ E M G

Name: _____ Date _____

Treatment Diagnosis: _____

Precautions: _____

Treat: ☐ Daily ☐ 3 times week ☐ 2 times week ☐ for _____ weeks

GOALS

☐ Relieve Pain ☐ Promote Healing ☐ Gain ROM ☐ Strengthen or Re-educate Muscles

☐ Increase Endurance ☐ Teach Functional Activities ☐ Teach Home Program

☐ Improve Coordination ☐ Prevent Deformity ☐ Maintain or improve Functional Level

HEAT
☐ Hot Packs
☐ Ultrasound
☐ Diathermy
☐ Paraffin

HYDROTHERAPY
☐ Whirlpool
☐ Contrast baths

CRYOTHERAPY
☐ Cold packs
☐ Ice massage
☐ Cold spray & stretch

TRACTION
☐ Cervical
☐ Pelvic
☐ Intermittent
☐ Constant
☐ Anti-gravity traction exercise program

ELECTRICAL STIMULATION
☐ Galvanic
☐ Faradic
☐ Transcutaneous nerve stimulation (TNS)
☐ Iontophoresis:
_____

REHABILITATION
☐ Pain control program
☐ Bio-feedback
☐ Hand
☐ Knee
☐ Stroke
☐ Amputee
☐ Gait training

EXERCISE
☐ Passive ROM
☐ Active ROM
☐ Strengthening (pre)
☐ Williams flexion
☐ Thoracic extension

ULTRASOUND
☐ Continuous
☐ US & Electrical stimulation-combination
☐ Phonophoresis

ORTHOTICS
☐ Custom fabricated lumbrosacral support
☐ Dorsal-Lumbar
☐ Support
☐ Hand splinting

TEST AND MEASUREMENTS
☐ Postural evaluation
☐ Muscle test (manual)
☐ Range of motion evaluation
☐ Grip strength

MOBILIZATION
_____ Joint: _____ Area
_____ Spinal: _____ Area

MASSAGE
☐ Sedative ☐ Deep ☐ Circulatory

Additional Orders/Goals _____

_____

Doctor's Signature _____

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