PROFESSIONAL THERAPEUTIC HEALTH CARE
3618 LANTANA RD, SUITE 202
LAKE WORTH, FL 33462
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THERAPY PRESCRIPTION

PATIENT INFO

Name: ___________________________________ DOB: _____________

Diagnosis: _______________________________

Precautions: _____________________________

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
◯ Myofacial 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: ____

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Physician Signature: _______________________________ **Date:** ___________

Physician Name: ____________________________________