REHAB THERAPY PARTNERS, INC.

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PHYSICAL THERAPY PRESCRIPTION / TREATMENT PLAN

Patient's Name: ________________________________ Phone: ____________________________
Type of Insurance: □ Work Comp. □ No Fault □ Medicare □ HMSA □ Other
Insurance Company: ____________________________ Claim#: ____________________________
Referring Physician: ____________________________ Phone: ____________________________
Diagnosis: ____________________________________ ICD-10: ____________________________
Date of Injury/Surgery: __________________________ Precautions: ________________________

PHYSICAL THERAPY EVALUATION AND TREATMENT — HOME PROGRAM

MODALITIES:	Moist Heat / Cryotherapy Whirlpool	Ultrasound Iontophoresis	Electrical Stimulation TENS
PROCEDURES:	Cervical / Lumbar Traction Joint Mobilization Spinal Mobilization	Myofascial Release Soft Tissue Mobilization Strain Counterstrain Craniosacral	Range of Motion Active / Passive Stretching Stabilization Resistive Exercise Strength/Conditioning
SPECIALIZED PROGRAMS:	Neck Back	Shoulder Elbow Wrist / Hand	Hip Knee Ankle / Foot
FUNCTIONAL TRAINING:	Gait Training	Work Hardening	Back School
CERTIFIED PROGRAMS:	Sportsmetrics™	STOTT PILATES®	

OTHER: ____
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MEASURABLE OBJECTIVES / GOALS: Please refer to enclosed report
FREQUENCY: daily 1x/wk 2x/wk 3x/wk
DURATION: _____ weeks

Number of sessions: _________________________ Cost Estimate: ____________________________
Estimated date of termination: _________________ Period to cover: ___________________________

______________________________________ ______________________
Physician's Signature Date