Lansing Rehabilitation Services

PHYSICAL THERAPY

Prescription for Physical Therapy

Patient's Name:	**DOB:**
Diagnosis:	
ICD-9 Code(s):	
Frequency: _____Times Per Week	**Duration:** _____Weeks
Precautions:	
Goals/ Comments/ Special Instructions:	

- ❒ Evaluate & Treat As Appropriate
- ❒ Therapeutic Exercise
  - ☐ Passive ROM
  - ☐ Active Assisted ROM
  - ☐ Active ROM
  - ☐ Strengthening
  - ☐ Stretching/ Flexibility
  - ☐ Scapular Stabilization
  - ☐ Closed Chain Exercises
  - ☐ Home Exercise Program
- ❒ Manual Therapy (soft tissue mobilization, joint mobilization, manual traction, massage, myofascial release)
- ❒ Neuromuscular Reeducation (Balance, Posture, Body Mechanics, Coordination)
- ❒ Lumbar Stabilization Exercise
  - ☐ Extension Based Program
  - ☐ Flexion Based Program
- ❒ Modalities
  - ☐ Moist Heat
  - ☐ Cryotherapy/ ICE
  - ☐ Electrical Stimulation
  - ☐ Ultrasound
  - ☐ Phonophoresis w/_____
  - ☐ Iontophoreses w/ _____
  - ☐ Traction
  - ☐ Paraffin
  - ☐ Taping
  - ☐ Orthotics/ Splinting
  - ☐ Brace _____
  - ☐ Low Level Laser (Hartsdale)
- ❒ Balance Training
- ❒ Gait Training
- ❒ Posture/ Body Mechanics
- ❒ Aerobic Conditioning
- ❒ Prosthetic/ Orthotic Training
- ❒ Pelvic Floor Rehab (Non-Internal)
- ❒ Other _____
- ❒ Special Programs
  - ☐ Hand Therapy (CHT/OT)
  - ☐ Pediatric Physical Therapy
  - ☐ TMJ/Craniofacial/Headache
  - ☐ Vestibular Rehabilitation
  - ☐ Balance & Fall Prevention
  - ☐ Arthritis Program
  - ☐ Osteoporosis Program
  - ☐ Work Hardening/ Conditioning
  - ☐ Low Back & Neck Pain
  - ☐ Prenatal (Low Back/ Pelvic Pain)
  - ☐ Neuro Rehab/ Post Stroke
  - ☐ Arthritis Program
  - ☐ Post-Mastectomy Rehab

Physician's Name (Print): _____

Physician's Signature: _____

License #: _____ **Date:** _____

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