



## PRESCRIPTION FOR PHYSICAL THERAPY

DATE: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

DIAGNOSIS: \_\_\_\_\_

FREQ/DURATION/ # of VISITS for TREATMENT: \_\_\_\_\_

PRECAUTIONS: \_\_\_\_\_

ADDITIONAL INFORMATION: \_\_\_\_\_

Evaluate and Treat

Therapeutic Exercise

Neuromuscular Re-Education

Soft Tissue Mobilization

ART (Active Release Techniques)\*

Graston Technique\*

*\* Location and practitioner specific*

Joint Mobilization

Gait Training

Alter G Anti-Gravity Treadmill\*

*\*Wilmington office only*

Modalities:

Electric Stimulation

Ultrasound/Phonophoresis

Iontophoresis

Moist Heat/Cryotherapy

Cervical Traction

Functional Training

Functional Screen

Pool Therapy

(Not available at MAC offices – please call for further information)

Postural Re-Education

Home Program Instruction

REFERRING PHYSICIAN SIGNATURE: \_\_\_\_\_

REFERRING PHYSICIAN FAX #: \_\_\_\_\_

**\*\*NOT FOR DISPENSING OF MEDICATION\*\***