



**BELVIDERE REHAB
& SPORTS MEDICINE**

Matt Greenwood, PT
Philip Hix, PT, DPT, MTC

*Certified Specialists
in Physical Therapy*

NAME: _____

PHONE: _____ DX CODE: _____

DIAGNOSIS: _____

DATE / TYPE OF SURGERY: _____

EVALUATION & TREATMENT

- | | |
|--|--|
| <input type="checkbox"/> Therapeutic Exercise | <input type="checkbox"/> Back Program |
| <input type="checkbox"/> Mobilization | <input type="checkbox"/> Gait Training |
| <input type="checkbox"/> Proprioceptive Retraining | <input type="checkbox"/> ROM |
| <input type="checkbox"/> Functional Restoration | <input type="checkbox"/> Home Program |

MODALITIES OF CHOICE

- | | |
|--|--|
| <input type="checkbox"/> Ultrasound | <input type="checkbox"/> Paraffin |
| <input type="checkbox"/> Electrical Stimulation | <input type="checkbox"/> Traction |
| <input type="checkbox"/> Iontophoresis Dexamethazone | <input type="checkbox"/> Hot/Cold Pack |
| <input type="checkbox"/> Tens | <input type="checkbox"/> Whirlpool |
| <input type="checkbox"/> Bracing _____ | |
| <input type="checkbox"/> Orthotics _____ | |

FREQUENCY: _____ PER WEEK, FOR _____ WEEKS

INSTRUCTIONS/PRECAUTIONS: _____

DR. _____ DATE: _____

Patients are offered appointments within 48 hours.

PLEASE CHECK HERE IF PATIENT NEEDS TO BE SEEN SOONER.

- This prescription is a statement of medical necessity for the above named patient -