PHYSICAL THERAPY

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Matt Greenwood, PT, Cert. DN

Certified Specialists in Physical Therapy

NAME:____

PHONE:____________________ DX CODE:____________________

DIAGNOSIS:____

____

DATE / TYPE OF SURGERY:________________________________

☐ **EVALUATION & TREATMENT**

- ☐ Therapeutic Exercise
- ☐ Mobilization
- ☐ Proprioceptive Retraining
- ☐ Functional Restoration
- ☐ Back Program
- ☐ Gait Training
- ☐ ROM
- ☐ Home Program

☐ **MODALITIES OF CHOICE**

- ☐ Ultrasound
- ☐ Electrical Stimulation
- ☐ Iontophoresis Dexamethazone
- ☐ Tens
- ☐ Bracing/Orthotics
- ☐ Paraffin
- ☐ Traction
- ☐ Hot/Cold Pack
- ☐ Whirlpool
- ☐ Dry Needling

FREQUENCY:________________ PER WEEK, FOR__________ WEEKS

INSTRUCTIONS/PRECAUTIONS:______________________________

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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 -

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