Physical/Occupational Therapy Prescription

Name: _____ Date of Birth: _____

Diagnosis: _____ Code: _____

Procedure: _____ Surgery Date: _____

Instructions:

Range of motion _____

_____

Strengthening _____

_____

Limitations _____

_____

___Continue Current Treatment ___Progress as tolerated

___ Home exercise program

___ Functional Capacity Evaluation ___ Work Hardening/Conditioning

Modalities

___ Electrical Stimulation ___ Iontophoresis ___ Laser therapy ___ Graston Technique

___ Heat ___ Ice ___ Massage ___ Per therapist

Frequency: 1 2 3 4 times/week Duration: 1 2 3 4 5 6 weeks

Signature: _____ Date: _____