Prescription / Plan of Care

FABIAN
PHYSICAL THERAPY LLC
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Patient Name :_____Phone:_____

DOB:_____Date of injury:_____

Physician:_____

Diagnosis/ICD9:_____

Precautions:_____

Other:_____

PHYSICAL THERAPY TREATMENT

___Evaluate & Treat ___Therapeutic Exercise ___Modalities ___Home program

___Manual Therapy (Joint mobilization, Soft tissue mobilization)

___Women's Health Treatments ___Vestibular Rehabilitation

Other_____

TREAMENT GOALS:

Improve: ____Function ___ROM ___Strength

Reduce pain from ____ to ____

Independence with home program:____

Other:_____

Duration/Frequency:_____ times per week for____ weeks. Total visits:_____

Thank you for referring this patient to my facility. If you have any questions or concerns, please feel free to contact us.

Physician Signature_____Date_____

(By signing above, I certify that the above treatment is medically necessary and reasonable).