



## Outpatient Physical Therapy Rx

Date \_\_\_\_\_

Referring Physician Name \_\_\_\_\_ Phone # \_\_\_\_\_

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

Patient Cell Phone # \_\_\_\_\_

Diagnosis \_\_\_\_\_

Comments / Precautions \_\_\_\_\_

### Prescription:

- Physical Therapy       Evaluate & determine modalities, treatments & frequency of treatments

### Therapeutic Exercise

- Active-Assisted ROM
- Active / Resistance
- Isometric
- Core Strengthening
- Postural Exercises
- Scapular Stabilization
- Aerobic Conditioning
- Gait Training
- Balance Training

### Manual Therapy

- Traction
- Joint Mobilization / Manipulation
- MFR
- Stretching
- Passive ROM
- Pre-op Education & Therapy
- Post-op Physician Specific Protocol  
*(please include protocol in fax)*

### Modalities

- Ultrasound
- Phono / Iontophoresis
- TENS / IFC
- Muscle Stim
- Taping
- Mech. Traction
- Trigger Point Dry Needling
- McKenzie Assessment

Frequency / Duration: \_\_\_\_\_ time(s) per week for \_\_\_\_\_ weeks

\_\_\_\_\_  
Physician Signature

**Phone: (512) 569-7309**

**Fax: (512) 533-0003**

**10222 Pecan Park Blvd, #4**

**Austin, Texas 78729**

**[www.spineandsportspt.org](http://www.spineandsportspt.org)**