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Naples, FL 34103
(239) 649-2222 Phone
(239) 649-0522 Fax
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PRESCRIPTION FORM

Patient Name____

Diagnosis ____

Precautions ____

____

GOALS: ____Improve Gait/Mobility ____Improve Strength ____ Improve Balance and Coordination
____Improve ROM ____Decrease Pain ____Improve ADL Skills ____Improve Endurance

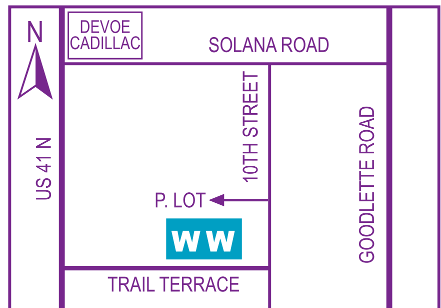
FREQUENCY & DURATION OF TX: ____x/wk. for ____wks

PHYSICAL THERAPY

____**Evaluate & Treat**
____Sports Specific Training
____Aquatic Ther. Ex.
____Ther. Ex. Strengthening
____Ther. Ex. ROM
____Gait/Transfer Training
____Balance & Safety Training
____Home Exercise Instruction
____Spinal Stabilization Ex.
____McKenzie Ex.
____Spinal Mobilization
____Massage

____Myofascial Release
____Modalities
____ E-Stim.
____ US
____ Iontophoresis
____Other__________________________

I certify that outpatient physical therapy is required.



____
Physician's printed name

____
Physician's signature

____
Date