PRESCRIPTION FOR PHYSICAL THERAPY SERVICES

Patient's name ___________________________  Date ___________________________
Address _________________________________  Phone ___________________________
______________________________ ___________________________
Date of birth ___________________________
Diagnosis _________________________________  Date of onset ______________________
Precautions ________________________________

☐ PHYSICAL THERAPY CONSULTATION AND TREATMENT
☐ FALL-RISK ASSESSMENT / FALL PREVENTION
☐ COMPUTERIZED DYNAMIC POSTUROGRAPHY (Sensory Organization /Adaptation)
☐ STRENGTH FOR LIFE MEMBERSHIP PROGRAM (Fitness program for adults age 55 and older)

TREATMENT: Per Examination Findings
☐ Canolith Repositioning  ☐ Vestibular Rehabilitation  ☐ Posture Training
☐ Balance Training  ☐ Neuromuscular Reeducation  ☐ Modalities PRN
☐ Electrical Stimulation  ☐ Functional Mobility Training  ☐ Gait Training
☐ Other ________________________________

Frequency ___________________________  Duration ___________________________

COMMENTS ___________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

Physician name ___________________________  Phone ___________________________
Physician signature ___________________________