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## PHYSICAL/OCCUPATIONAL THERAPY PRESCRIPTION

**CLIENT INFORMATION**

Name ________________________________________ Date ___________________

M.D. _________________________________________ Date of Injury ____________

Diagnosis/ICD10 ______________________________________________________________

Comments/Precautions: _____________________________________________________

___________________________________________________________________________

**EVALUATE & TREAT**
**Frequency/Duration** ____ Times per week for ____ Weeks. ____ Number of Visits

**SERVICES**
__ Strength / ROM / Stretching
__ Back / Neck Rehab / Stabilization
__ Patient Education
__ Aerobic Conditioning
__ Home Exercise Program
__ Balance / Gait Training
__ Joint Mobilization
__ Kinesiotaping method
__ A.R.T / MFR
__ Modalities
__ Other ____________________________________________________________________

I certify the medical necessity of this treatment plan.

Physician Signature ____________________________ Date ___________________

MD Phone ______________________ Fax ____________________

Thank you for this referral!

**PLEASE BRING THE FOLLOWING TO YOUR INITIAL VISIT:**
1) Your physical/occupational therapy prescription *(this form)*
2) Your Insurance Card
3) Loose fitting clothing, shorts, or workout attire