203 Kentucky Avenue
Kevil, KY 42053
(270) 462-8252
(270) 462-8253(fax)

PHYSICAL THERAPY PRESCRIPTION

Patient Name: ____ Date: __________________

Diagnosis/ICD-9:____

Comments/Precautions:

____

____

RX:

___ PT to Evaluate and Treat as Appropriate

Services:

___ Strength / ROM / Stretching

___ Back / Neck Rehab / Stabilization

___ Aerobic Conditioning

___ Home Exercise Program

___ Balance / Gait Training

___ Vestibular Rehabilitation

___ Other

___ Joint Mobilization

___ MFR

___ Massage

___ Modalities

___ Neuromuscular Re-educ

___ Pre-op/Post-op Rehab

Frequency: ______ by Physical Therapist's treatment plan

OR _________ times per week for _______ weeks.

Signature: __________________________ Date: __________

Thank you for this referral