PHYSICAL THERAPY PRESCRIPTION

Patient ____________________________ Date __________

Diagnosis ________________________________________

Precautions/Remarks ______________________________________

________________________

PHYSICAL THERAPY

☐ Therapist to evaluate and determine use of procedures, modalities.

☐ Other ____________________________

OTHER SPECIALTIES

☐ Aquatic Therapy ☐ TMJ Disorder

☐ Women’s Health ☐ TENS

☐ Back Class

MASSAGE THERAPY

☐ Massage

☐ Other ____________________________

HAND THERAPY

☐ Therapist to evaluate and determine use of procedures, modalities.

☐ Other ____________________________

Rx FREQUENCY ______ x per week for ______ weeks, or ______ PRN

☐ Therapists discretion

Patient Recheck with Physician (date) ____________________________

Physician Signature __________________________________________

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