CONSULTATION PHYSICAL THERAPY *of TEXAS*

RETURNING YOU TO THE GAME OF LIFE

Physical Therapy Prescription

Patient Name: _____ DOB: _____

Diagnosis: _____

Precautions/Comments: _____

Surgery: _____ SX Date: _____

Physician: _____ NPI: _____

Physician Phone #: _____ F/U Visit: _____

❑ **Evaluate & Treat** **Frequency:** _____x /week ❑ **Duration:** _____x weeks

PRN (passive modalities)
- ❑ Heat
- ❑ Cryotherapy
- ❑ Electrotherapy
- ❑ Ultrasound
- ❑ Phonophoresis
- ❑ Ionophoresis
- ❑ Traction

MANUAL THERAPY
- ❑ Myofascial Release
- ❑ Joint Mobilization/Manipulation
- ❑ Proprioceptive Neuromuscular Facilitation
- ❑ Stretching
- ❑ Desensitization
- ❑ Edema Management

RANGE OF MOTION
- ❑ Passive
- ❑ Active Assisted
- ❑ Active

EXERCISE
- ❑ Therapeutic Exercise
- ❑ Therapeutic Activities
- ❑ Neuromuscular Re-education
- ❑ Gait Training
- ❑ Biofeedback

REHABILITATION PROGRAMS
- ❑ Home Exercise Program
- ❑ SX Protocol _____
- ❑ McKenzie Protocol
- ❑ Balance Rehab Program
- ❑ Vestibular Rehabilitation
- ❑ Stroke Protocol
- ❑ Parkinson Protocol
- ❑ TMJ Treatment
- ❑ CRPS Rehab Protocol
- ❑ Blood Flow Restriction Rehab Protocol

NEEDLING
- ❑ Dry Needling
- ❑ Acupuncture

DIAGNOSTICS
- ❑ MSK Ultrasound
  - ❑ _____
- ❑ EMG/NCV
  - ❑ Upper Extremity
  - ❑ Lower Extremity
  - ❑ _____

❑ **TENS Fitting**

❑ Far Infrared Sauna

Other: _____

_____ _____

Physician Signature **Date**

Please fax this referral prescription to 713-961-0812. Thank you.

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