



# 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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