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A Division of Licking Rehabilitation Services, Inc.

PICKERINGTON
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A Division of Rehabilitative Associates, Inc.

PHYSICAL / OCCUPATIONAL THERAPY PRESCRIPTION

Patient ______________________________ Phone ______________

Date _______________ Referring Dr. ___________________________

Diagnosis ________________________ ICD-9 Code ____________

Date/Type of Surgery ______________________________________

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Special Instructions/Precautions ___________________________

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Treatment Plan

❒ Therapist's Discretion

Frequency of Treatment ______ Day(s)/Week Duration of Treatment ______ Week(s)

Treatment

❒ EVALUATE AND TREAT
❒ Aerobic Conditioning
❒ Back School
❒ Cold/Heat Treatments
❒ Electrical Stimulation
❒ EMG/Biofeedback
❒ Exercise ___________
❒ Fitness/Wellness Prog.
❒ Functional Capacity Eval
❒ Gait Training
❒ Hand Therapy
❒ Home Instruction
❒ Iontophoresis
❒ Isokinetic Ex/Test
❒ Job Analysis
❒ Joint Mobilization
❒ Massage, Soft Tissue
❒ Myofascial Release
❒ Orthotics / Splinting
❒ Pelvic Floor Conditioning
❒ Phonophoresis
❒ Traction ___________
❒ Ultrasound
❒ Work Conditioning