Pain Specialties
Pain Control for Adults & Children

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PRESCRIPTION FOR PHYSICAL THERAPY

Patient Name: _____

Diagnosis: _____

Referring Physician: _____ Phone # _____

❑ **Evaluate and Treat**

Modalities

❑ Hot Pack ❑ Iontophoresis ❑ Phonophoresis
❑ Cold Pack ❑ Ultrasound ❑ Microcurrent
❑ Electric Stim ❑ Massage ❑ Modalities PRN:at P.T.s discretion

Exercises

❑ Active ROM ❑ Strengthening ❑ Conditioning
❑ Passive ROM ❑ PRE's ❑ Gait Training
❑ Stretching ❑ Isometrics ❑ Home Program

Goals of Treatment

❑ Decrease Pain ❑ Improve Functional Abilities
❑ Decrease Edema ❑ Increase ROM/Flexibility
❑ Increase Endurance ❑ Improve Gait, Weight Bearing Status _____
❑ Increase Strength ❑ Progress Weight Bearing to _____

Frequency of Treatment 1 2 3 4 5 Days/wk –for 2 4 6 8 12 ____ weeks

Additional Comments:

_____ _____
Date Physician Signature

(My signature authorizes this treatment to be medically necessary)