SOUTH COUNTY PHYSICAL THERAPY AND REHABILITATION CENTER, INC.

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www.southcountyphysicaltherapy.com

"A STEP IN THE RIGHT DIRECTION"

PHYSICAL MEDICINE PRESCRIPTION

NAME _____ DATE _____

DIAGNOSIS _____

FREQUENCY OF TREATMENT
❑ DAILY ❑ 3X WK ❑ 2X WK ❑ 1X WK
❑ 2 WKS ❑ 3 WKS ❑ 4 WKS ❑ 6 WKS

PHYSICAL THERAPY

_____ **EVALUATE AND TREAT**
_____ HOT PACKS
_____ COLD PACKS
_____ FLUIDOTHERAPY
_____ ULTRASOUND
_____ ULTRASOUND W/STIM
_____ MASSAGE
_____ HIGH VOLTAGE GALV. STIM
_____ INTERFERENTIAL STIM.
_____ COLD LASER
_____ BACK SCHOOL
_____ JOBST
_____ TRACTION
  _____ CERVICAL
  _____ PELVIC
_____ PARAFFIN
_____ WHIRLPOOL
_____ DEBRIDE & DRESS
_____ CONTRAST BATH
_____ TENS
_____ INFRARED
_____ HAND REHABILITATION
_____ BALANCE
_____ DIZZINESS
_____ DRY NEEDLING
_____ _____
_____ _____
_____ _____
_____ _____

_____ **KINETIC ACTIVITIES**
_____ EXERCISE
_____ PASSIVE
_____ ACTIVE
_____ RESISTIVE
_____ COORDINATION
_____ WILLIAMS
_____ POSTURAL
_____ NECK & SHOULDER
_____ HOME EXERCISE PROGRAM
_____ McKENZIE
_____ CRANIAL SOFT TISSUE RELEASE
_____ NEURO MUSCULAR RE EDUCTION

GAIT TRAINING
_____ WEIGHT BEARING
_____ NON WEIGHT BEARING
_____ PARTIAL WEIGHT BEARING
_____ GRAD. WEIGHT BEARING

OTHER
_____ BMI CONSULT

GOALS
_____ ↓ PAIN
_____ ↓ EDEMA
_____ ↑ RANGE OF MOTION
_____ ↑ FUNCTIONAL ABILITY
_____ ↑ STRENGTH

PRECAUTIONS/SPECIAL INSTRUCTIONS _____

_____

_____

I certify that the above treatment is medically necessary and is approved.

_____ M.D. _____ D.O.