TruWell PHYSICAL THERAPY

Rehabilitation Prescription

24/7 Schedule Online!

Patient Name: _____

Phone: _____

Evaluate & Treat: PT _____ times per week for _____ weeks

Diagnosis: _____

Precautions and/or Special Instructions: _____

_____

- ☐ Range of Motion: ☐ Active ☐ Passive
- ☐ Gait Training
- ☐ Neuromuscular Retraining
- ☐ Therapeutic Exercise
- ☐ Stretching
- ☐ ADL Activities
- ☐ Postural Retraining
- ☐ Balance Activities
- ☐ Back Education Program
- ☐ Healthy Lifestyle
- ☐ Home Exercise Program
- ☐ Pelvic Floor Training
- ☐ Moist Heat
- ☐ Cold Pack
- ☐ Ultrasound
- ☐ Electrical Stimulation
- ☐ Iontophoresis
- ☐ Phonophoresis
- ☐ Traction: ☐ Cervical ☐ Lumbar
- ☐ Massage
- ☐ Kinesiology Taping
- ☐ Craniosacral
- ☐ Instrument Assisted Soft Tissue Mobilization/Graston®

Other: _____

_____

*Referring Medical Provider: _____

Date: _____

*By signing this referral, Medical Provider certified that the prescribed Rehabilitation is medically necessary.

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