FRUITION PHYSICAL THERAPY

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A DIVISION OF FRUITION THERAPY, LTD, A WISCONSIN CORPORATION

PRESCRIPTION FOR PHYSICAL THERAPY

Patient Name:_____________________________ **Date of Birth:**________________

Telephone Number:_____________________________

Diagnosis:____

Precautions:____

❑ **Evaluate and Treat** ❑ **Continue Physical Therapy**

Frequency: 1x_____ **2x**_____ **3x**_____ **4x**_____ **5x**_____

Duration: 1wk_____ **2wk**_____ **3wk**_____ **4wk**_____ **5wk**_____ **6wk**_____

- ❑ **Balance Training / Neuro Re-education**
- ❑ **Flexibility**
- ❑ **Home Exercise Program Instruction**
- ❑ **Modalities**____
  - ❑ **Iontophoresis with Dexamethasone**
  - ❑ **Ultrasound**
  - ❑ **Electrical Stimulation**
- ❑ **Manual Therapy / Soft Tissue Mobilization**
- ❑ **Postural/Body Mechanics Instruction**
- ❑ **Therapeutic Exercise** ❑ **AROM** ❑ **PROM** ❑ **Strengthening**
- ❑ **Issue Home Traction Unit** ❑ **Cervical** ❑ **Lumbar**
- ❑ **Issue Home Electrical Stimulation Unit** ❑ **NMES** ❑ **TENS**
- ❑ **Other**____

Date of Next MD Appointment:__________________
Physician Comments:____

Physician Signature:________________________________ **Date:** __________________

Please fax back to 262-723-2734