SUMMIT REHABILITATION L.L.C.

Physical Therapy Prescription

LAKE STEVENS • MARYSVILLE • MILL CREEK
SNOHOMISH • SULTAN

Patient _____ Date _____

Diagnosis _____

Precautions / Remarks _____

_____

X-Ray / Test Results _____

_____

Instructions:

❑ **Evaluate & Treat** ❑ **Women's Health**

❑ Evaluation Only ❑ Orthotics

❑ Soft Tissue Mobilization ❑ Joint Mobilization

❑ Exercise: _____

❑ Modalities: _____

❑ Augmented Soft Tissue Mobilization: _____

❑ Comments or Special Orders: _____

_____

Treatment Plan:

❑ **Therapist's Discretion**

Frequency / Duration: 1 2 3 4 5 Times per week for _____ Weeks

Additional Comments: _____

_____

Physician Re-Check Date: _____/_____/_____

Physician's Signature: _____

Thank you for this referral.

9-05