

# *In Touch*

## *Physical Therapy*

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*Hands on care you can trust.*



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### **Physicians Prescription for Physical Therapy**

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_  
Phone Number H: \_\_\_\_\_ W: \_\_\_\_\_  
Diagnosis \_\_\_\_\_  
Prescribing Physician \_\_\_\_\_

Post Op?  Yes  No Date of surgery \_\_\_\_\_  
Work Comp?  Yes  No Date of injury \_\_\_\_\_

#### **\_\_\_\_ Evaluation and Treatment \_\_\_\_ Protocol**

- PROM, AAROM, AROM
- Joint and soft tissue mobilization techniques as indicated
- Neuromuscular techniques and exercises as indicated
- Principles of functional activities and postural devices as indicated
- Instruction in a home exercise program as appropriate
- Use of modalities, PRN
- Use of hydrocortisone for ionto/phonophoresis
- AQUATIC THERAPY

Comments/Precautions: \_\_\_\_\_  
\_\_\_\_\_

Number of Visits: \_\_\_\_\_ or \_\_\_\_\_ x/week for \_\_\_\_\_ weeks

Physicians Signature \_\_\_\_\_

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*123 West Broadway Street  
Owatonna MN 55060*

*Phone: 507 451 7888  
Fax: 507 451 3322*