



Prescription For Therapy Plan of Care

Patient _____ Date _____

Diagnosis _____

Comments _____

Plan of Care

- Evaluate & Treat Frequency: 3x 2x Other _____
- Modify as Needed Duration: 4wk 3wk Other _____
- Evaluate & Consult - 1 Visit
- Two Week Trial & Consult

Manual Therapy

- Therapist Discretion
- Other _____

Modalities

- Therapist Discretion
- Other _____

Exercise

- Therapist Discretion
- Other _____

Special Programs

- Joint Pain
- Spine Rehabilitation
- Athletic Injury Rehab/Prevention
- Temporomandibular Joint Treatment
- Total Joint Replacement
- Balance and Fall Prevention

Physician's Signature _____
I authorize this treatment, which is medically necessary for the above named patient.

Physician's Printed Name _____



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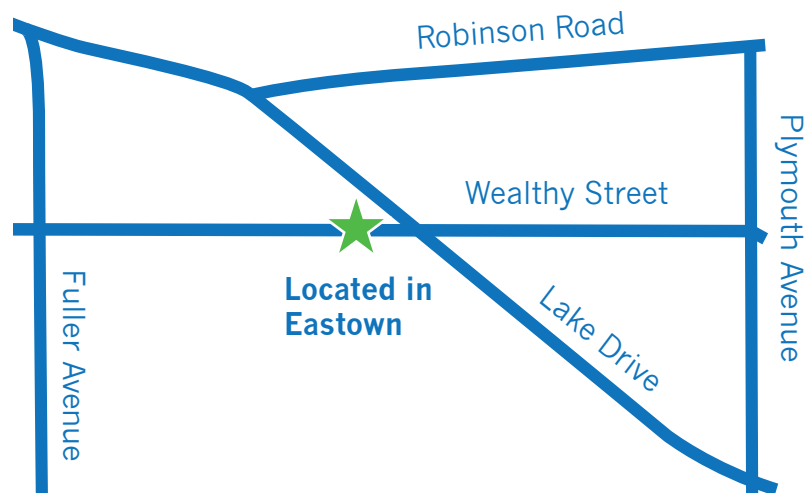
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616.456.0360



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