PRIME PT

Age Is Only A Factor If You Allow It To Become One

Physical Therapy Prescription Form

Patient's name: _____ DOB: _____ Date of referral: _____

Phone number(s): _____ Injury/Surgery date: _____ N/A: [ ]

Diagnosis/ICD-10: _____

OR circle: Pain in R/L shoulder (M25.511/M25.512) Pain in R/L elbow (M25.521/M25.522) Pain in R/L hip (M25.551/M25.552) Pain in R/L knee (M25.561/M25.562) Pain in R/L ankle/foot (M25.571/M25.572) Cervicalgia (M54.2) Low back pain (M54.5) Pain in R/L arm (M79.601/M79.602) Pain in R/L leg (M79.61 /M79.62) Pain in R/L thigh (M79.651/M79.652) Pain in R/L lower leg (M79.671/M79.672) Unspecified knee sprain (S83.509) Lumbar sprain (S33.5) Cervical sprain (S13.4) Muscle weakness (M62.81) Difficulty walking (M26.2) R/L shoulder sprain (S43.421/S43.422) Generalized OA (M15.0)

Medical Insurance: _____ Member number: _____

Workers' Comp: [ ] No Fault: [ ] Claim number: _____

[ ] Evaluate and treat accordingly

[ ] Administer _____

OR check from the following options: [ ] Therapeutic exercises/activities [ ] Manual therapy

[ ] Neuromuscular re-education [ ] Strapping/taping [ ] Other: _____

Frequency and duration: _____ times per week, for _____ weeks.

_____

Physician's Signature Date

_____

Physician's Name (print)