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Physical Therapy Prescription

Patient Name: _____ DOB: _____

Physician Name: _____ Follow up date: _____

Diagnosis: _____ ICD 10: _____

Precautions/ Special Notes: _____

Neurologic Physical Therapy

Evaluate and Treat

- Stroke
- Brain Injury
- Spinal Cord Injury
- Parkinsons Disease
- Multiple Sclerosis
- Transverse Myelitis
- Cerebral Palsy
- Motor Neuron Diseases
- Demyelinating Disorders of the nervous system, AIDP/CIDP
- Muscular Dystrophies
- Peripheral Neuropathies
- Post-op Neuro surgical Procedures

Goals of Treatment

- Increase functional Independence
- Reduce falls and unsteadiness
- Improve Balance

Physical Therapy Treatment

- LSVT BIG
- Vestibular Therapy
- Functional Training

Geriatric Physical Therapy

Evaluate and Treat

- Osteoporosis
- Age-related physical debility
- Muscle weakness (generalized)
- Postural kyphosis
- Falls and Balance Dysfunction
- Vestibular Dysfunction
- Abnormality of Gait
- Deconditioning/ Debility
- Ataxia

- Evaluate Adaptive equipment
- Return to work/school
- Return to play/sports

- Strengthening and endurance
- Restore Movement and ROM

Musculoskeletal Physical Therapy

Evaluate and Treat

- Back Rehab
- Neck Rehab
- Shoulder Rehab
- Elbow and Wrist Rehab
- Hip Rehab
- Knee Rehab
- Ankle and Foot Rehab
- Concussion

- Improve range of Motion
- Improve overall strength
- Address Postural Dysfunction

- Balance Training
- Gait training

Frequency of Treatment (Standard treatment plan)

- 2-3 times a week for 4 weeks 6 weeks 8 weeks 12 weeks

I certify that physical therapy is medically necessary for this patient's plan of care.

Physician Signature

Date