CLAIR
PHYSICAL THERAPY

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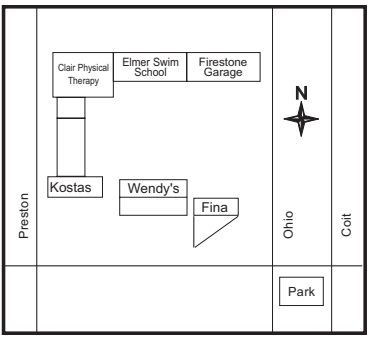

Patient Name: _____ DOB: _____

Patient Phone Number: _____

Diagnosis: _____

Surgical Procedure: _____

Precautions: _____

☐ EVALUATE AND TREAT

Therapeutic Exercise
- ☐ Home Exercise Program
- ☐ Strengthening
- ☐ ROM
- ☐ Flexibility
- ☐ Neuromuscular Re-Education
- ☐ Gait Training
- ☐ Functional Training
- ☐ Post-Op Rehab

Modalities
- ☐ As Indicated
- ☐ Cold/Heat
- ☐ Ultrasound
- ☐ Electrical Stimulation
- ☐ Iontophoresis
- ☐ Phonophoresis
- ☐ Traction - Cervical/Lumbar
- ☐ Cold Laser

Manual Therapy
- ☐ Joint Mobilizations
- ☐ Myofascial Release
- ☐ McKenzie Program
- ☐ Muscle Energy Techniques
- ☐ Soft Tissue Mobilization

☐ **Work Conditioning** ☐ **Fall Risk Assessment** ☐ **Sport Specific Training**

Special Instructions: _____

Frequency: _____ Duration: _____

Total Visits: _____

I hereby certify the above services to be medically necessary.

Signature: _____ Date: _____

DO NOT EMAIL PRESCRIPTION The electronic prescription form is provided for your convenience. With respect to responding to this form, please do not send the prescription via email. Please populate, print and sign a hardcopy that may be faxed, mailed or hand delivered to the clinic.