626 N Ave F, Mason Texas 76856
To schedule an appointment, please call (325) 294-4700

PHYSICAL THERAPY PRESCRIPTION

Patient Name : ____ DOB _______________

Physician: ____

Diagnosis : ____

Precautions : ____

Order: ____

☐ Evaluate & Treat ☐ Frequency & Duration_____________________________
☐ Home Safety Evaluation ☐ Home Equipment/Modification Assessment and Training
☐ Transfer Training ☐ Orthotics Fit/Training ☐ Balance Training
☐ Home exercise program ☐ Gait Training ☐ Dry Needling
☐ Therapeutic Exercise ☐ LSVT/Parkinsons ☐ Vestibular Rehab
☐ Massage/Soft tissue ☐ Manual Therapy/Joint mobility
☐ Neuromuscular Training

Goals:

☐ Improve ROM ☐ Improve strength ☐ Improve mobility ☐ Improve function

Other:____

X____
Physician Signature

Please fax this referral slip to 325-294-4701, and include patient demographic sheet with orders. Thank You!

☐ Check if more referral pads needed