General Physical Therapy Prescription

Patient Name: Date:

Diagnosis: _____ Operative / Non-Operative

Number of visits each week: 1 2 3 4 Treatment duration_____weeks

__ Evaluate and treat

Specifics (if not online as noted below):

_____

_____

_____

_____

__ Prescription protocol is available at _____
(located in physical therapy forms link)

Physician Signature: