



www.PTAcclinic.com
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Physical Therapy • Aquatic Therapy

Patient Name: _____ Date: _____

Contact Phone: _____

Diagnosis/ ICD 10 code: _____

Precautions/ Restrictions: _____

Frequency: _____ Duration: _____

Prescription Form for PHYSICAL THERAPY

☐ Land Physical Therapy

- ☐ Evaluate and Treat
- ☐ Modalities
- ☐ Neuromuscular Re-Education
- ☐ Traction
- ☐ Manual Therapy

☐ Aquatic Physical Therapy

- ☐ Therapeutic Exercises
- ☐ AROM
- ☐ PROM
- ☐ Strengthening
- ☐ Stretching

SPECIALTY PROGRAMS

- | | |
|---|--|
| <input type="checkbox"/> Balance/ Fall Prevention | <input type="checkbox"/> Work Injury/ Return to work |
| <input type="checkbox"/> Pre-Operative Management | <input type="checkbox"/> Post Operative Management |
| <input type="checkbox"/> Sports Specific Training | <input type="checkbox"/> Aerobic Conditioning |

Special Instructions:

I certify that the above named patient is under my care and requires physical therapy services:

On an outpatient basis and under a plan established and reviewed within 30 days by me as

Physician's Signature _____