IMPORTANT
Bring this prescription and any HMO referral, Auto or Worker's Comp authorizations on your first day.

ADVANCED Physical Therapy Center

Part of the **Phoenix** family!

❑ *PRESCRIPTION*

Grand Blanc (810) 695-8700
Fax (810) 695-7946
Clio (810) 687-8700
Fax (810) 687-8724
Flint (810) 732-8400
Fax (810) 732-4075
Hartland (810) 632-8700
Fax (810) 632-5850
Goodrich (810) 636-8700
Fax (810) 636-8702
Davison (810) 412-5100
Fax (810) 412-5106
Clarkston (248) 620-4260
Fax (248) 620-4239
Waterford (248) 618-3050
Fax (248) 618-3284
Fenton (810) 354-7522
Fax (810) 355-4873

Date_____Patient Phone Number_____

Name_____

Diagnosis_____

Precautions_____

Physical / Occupational / Hand Therapy

❑ EVALUATE AND TREAT PER CARE PLAN
❑ HOME EXERCISE PROGRAM
❑ SELF-CARE EDUCATION

❑ THERAPEUTIC EXERCISE
- **❑ Passive ROM**
- **❑ Active-Assisted ROM**
- **❑ Progressive Resistive Exercise**

❑ MANUAL MOBILIZATION
❑ NEUROMUSCULAR RE-EDUCATION
❑ THERAPEUTIC ACTIVITIES

❑ EXERCISE:
- ❑ AlterG Anti-Gravity Treadmill
- ❑ Aquatic Therapy
- ❑ Cervical/Lumbar Strengthening
- ❑ Core Strengthening
- ❑ Gait and Balance Training
  - ❑ WB Status: _____
- ❑ MedX Testing/Rehab
- ❑ Sports Rehab

❑ MANUAL TECHNIQUES:
- ❑ CranioSacral Therapy
- ❑ Functional Dry Needling
- ❑ Graston Technique
- ❑ Joint Mobilization
- ❑ Myofascial Decompression
- ❑ Myofascial Release
- ❑ Soft-Tissue Massage

❑ MODALITIES:
- ❑ Biofeedback
- ❑ Traction
  - ❑ Cervical
  - ❑ Pelvic
- ❑ Contrast Bath/Whirlpool
- ❑ Electrical Stimulation
- ❑ Game Ready Pneumatic Compression
- ❑ Hivamat Deep Oscillation Therapy
- ❑ Iontophoresis
- ❑ Light/Laser Therapy
- ❑ TENS
- ❑ Ultrasound/Phonophoresis
- ❑ WellWave Acoustic Compression Therapy

❑ HAND THERAPY:
- ❑ ADL Activities: _____
- ❑ Orthotic Fabrication: _____
- ❑ Paraffin Bath/Fluidotherapy
- ❑ Pinch/Grip Strengthening
- ❑ Scar Massage/Desensitization
- ❑ Tendon Repair Protocol: _____

❑ PROGRAMS
- ❑ Advanced Spine & Neck Rehab
- ❑ Bone Health Program
- ❑ Concussion Program
- ❑ Functional Capacity Evaluation
  - ❑ Work Reconditioning/Hardening
  - ❑ Return-to-Work Assessment
  - ❑ Disability Screening
- ❑ Lymphedema Treatment
- ❑ Parkinson's LSVT Big Program
- ❑ Pelvic Floor Therapy
  - ❑ Women's Health Program
- ❑ Sportsmetrics
- ❑ Vestibular Rehab
- ❑ TMJ Disorder Rehab

❑ Other: _____

_____

❑ 3 x Weekly ❑ 2 x Weekly ❑ Daily **Number of visits**_____

for_____**weeks**_____**months**

I ❑ certify that I have examined the patient and physical and/or occupational therapy is necessary, and that services will be furnished while the patient is under my care, and that the plan is established and will be reviewed every ninety (90) days or more often if the patient's condition requires. I estimate that these services will be needed for 90 days.

℞ _____

Physician Signature NPI# Date