Resilience Physical Therapy and Wellness

Patient Name:____DOB:____________________

Diagnosis:______________________________Precautions/Comments:____________________________

Surgery:_____________________________SX Date:____________ Physician:__________________

NPI:____________________Physician Phone #:________________________ F/U Visit:______________

❑ Evaluate and Treat

Frequency ______________/week

Duration______________x weeks

PRN (passive modalities)

- ❑ Heat
- ❑ Cryotherapy
- ❑ Electrotherapy
- ❑ Ultrasound
- ❑ Phonophoresis
- ❑ Ionophoresis
- ❑ Traction

MANUAL THERAPY

- ❑ Myofascial Release
- ❑ Joint Mobilization/Manipulation
- ❑ Proprioceptive Neuromuscular Facilitation
- ❑ Stretching
- ❑ Desensitization
- ❑ Edema Management

RANGE OF MOTION

- ❑ Passive
- ❑ Active Assisted
- ❑ Active

EXERCISE

- ❑ Therapeutic Exercise
- ❑ Therapeutic Activities
- ❑ Neuromuscular Re-education
- ❑ Gait Training
- ❑ Biofeedback

REHABILITATION PROGRAMS

- ❑ Home Exercise Program

- ❑ SX Protocol ____________________
- ❑ McKenzie Protocol
- ❑ Balance Rehab Program
- ❑ Vestibular Rehabilitation
- ❑ Stroke Protocol
- ❑ Parkinson Protocol
- ❑ TMJ Treatment
- ❑ CRPS Rehab Protocol
- ❑ Blood Flow Restriction Rehab Protocol

NEEDLING

- ❑ Dry Needling

Other: ____

____ ____________________

Physician Signature Date

Please fax this referral prescription to 413-789-8140 . Thank you.

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www.resilienceptwellness.com

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