Signature PHYSICAL THERAPY

4215 N. Classen Blvd., Suite 102 • Oklahoma City, OK 73118
Telephone: 405-840-1467 • Fax: 405-840-2960 • www.signaturept.net

Patient Name: _____ Date: _____

Diagnosis: _____

Precautions: _____

Frequency/Duration: _____ times/week for _____ weeks

☐ EVALUATE & TREAT

❑ THERAPEUTIC EXERCISE
- ❑ Passive ROM
- ❑ Active ROM
- ❑ Progressive Resistive Exercise
- ❑ Proprioceptive
- ❑ Stabilization
- ❑ Posture/Body Mechanics
- ❑ Gait Training
- ❑ Balance Training

❑ MODALITIES
- ❑ Ultrasound
- ❑ Phonophoresis
- ❑ Iontophoresis
- ❑ Electrical Stimulation
- ❑ Intermittant Cervical/ Lumbar Traction

- ❑ Knee Rehab
- ❑ Shoulder Rehab
- ❑ Ankle Rehab
- ❑ Manual Therapy
- ❑ Home Exercises
- ❑ Sports Specific Training
- ❑ Neuromuscular Re-education

GOALS OF TREATMENT

- ❑ Return To Work
- ❑ Restore Function
- ❑ Decrease Edema
- ❑ Improve Strength
- ❑ Improve Flexibility
- ❑ Other _____
- ❑ Improve ROM
- ❑ Decrease Pain
- ❑ Improve Gait

Special Instructions: _____

_____

_____

The above plan of care is established and will be reviewed every 30 days. I certify the medical necessity of therapy.

Signature: _____ Date: _____

DO NOT EMAIL PRESCRIPTION The electronic prescription form is provided for your convenience. With respect to responding to this form, please do not send the prescription via email. Please populate, print and sign a hardcopy that may be faxed, mailed or hand delivered to the clinic.

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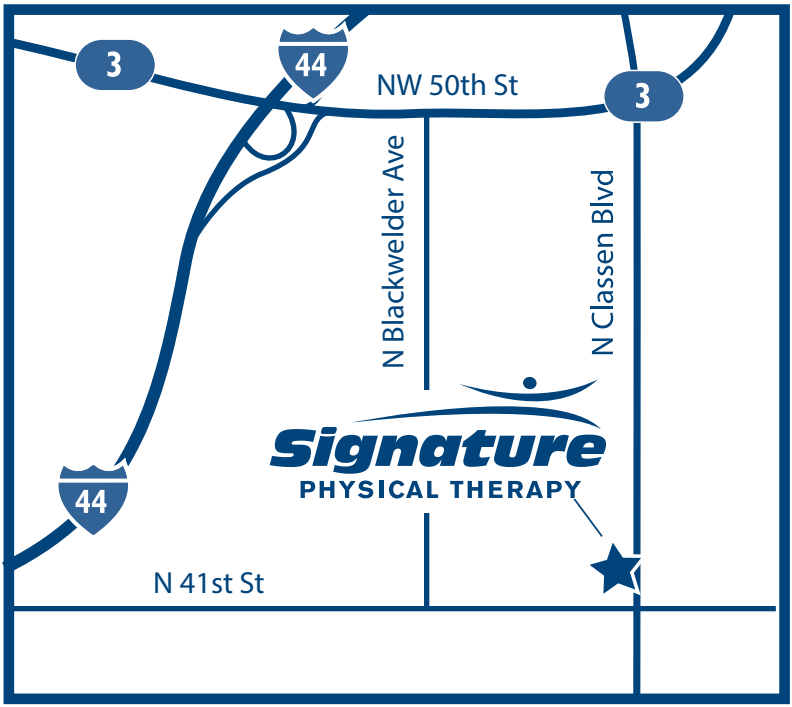

JUST A REMINDER:
Please bring this referral slip with you on your first visit.
Please arrive 15 minutes before your scheduled appointment to complete the necessary paperwork.
Evaluations (1st visit) usually last 1 to 2 hours.

WHAT TO WEAR:
Please wear/bring comfortable clothing and sneakers including T-shirts and shorts or sweatpants.