PRESCRIPTION

Patient_____________________________ Today's Date___________ Date of Injury___________

Diagnosis
*Include ICD-9 codes

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Condition is related to

- ☐ Auto Accident
- ☐ Work Injury
- ☐ Illness
- ☐ Other___________________________

Medically Necessary Treatment: Implement Plan as Prescribed Below

Areas of Application (Direct & Indirect)

- ☐ Head ☐ Neck ☐ Chest
- ☐ Shoulders ☐ Abdomen
- ☐ Hips/Buttocks ☐ Back
- ☐ Upper Extremities ☐ Lower Extremities
- ☐ All of the Above ☐ Other_______________

Treatment Type

- ☐ Manual/Massage Therapy
- ☐ Hot or Cold Packs
- ☐ Self-Care Education
- ☐ Other___________________________________

Duration & Frequency

- ☐ 1x week for ________ weeks
- ☐ 2x month for ________ months
- ☐ 1x month for ________ months
- ☐ Other___________________________________

Treatment Goals

- ☐ Decrease Pain
- ☐ Decrease Inflammation
- ☐ Decrease Muscle Tension/Spasms
- ☐ Decrease Compensatory Patterns
- ☐ Increase Mobility
- ☐ Increase Strength
- ☐ Restore Function
- ☐ Restore Posture
- ☐ Maintain Associated Structures
- ☐ All of the Above
- ☐ Other___________________________

Special Instructions _________________
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Referring Health Care Provider

Name____ Provider #______________________

Address____

Phone #_____________________________________ Fax #_________________________________

Signature____ Date______________________