4515 Ocean View Blvd. Suite 350 La Canada CA 91011
440 Foothill Blvd La Canada CA 91011
3000 Dolores St Los Angeles CA 90065
3810 La Crescenta Blvd La Crescenta Blvd. CA 91214
Ph: (818) 369-7620
FAX: (818) 369-7621

PRESCRIPTION FOR PHYSICAL THERAPY

Patient Name: _____

Diagnosis: _____

Surgical Procedure: _____

Frequency: _____**x/week for** _____ **weeks**

Specific Instructions:

_____

_____

_____

☐ EVALUATE AND TREAT

☐ MANUAL THERAPY ☐ GAIT TRAINING	
☐ THERAPEUTIC EXERCISE ☐ BALANCE/	FALL PREVENTION
☐ ROM ☐ CORE/ LUMBAR PROGRAM	
☐ RETURN TO THROWING	
☐ NEURO RE-EDUCATIONPROGRAM	
☐ MODALITIES ☐ SPORT SPECIFIC	TRAINING
☐ HEP/ PATIENT EDUCATION ☐ FUNCTIONAL TRAINING	

I hereby certify that I have examined this patient and have determined that Physical Therapy treatments are medically necessary.

Physician Signature: _____ **Date** _____

Physician Name: _____

Phone Number: _____