4515 OCEAN VIEW BLVD.
SUITE 320
LA CAÑADA, CA 91011
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
☐ NEURO RE-EDUCATION	☐ RETURN TO THROWING PROGRAM
☐ 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: _____

ASPIRE

PHYSICAL THERAPY &
SPORTS PERFORMANCE

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