On The MOVE therapy

TOLL-FREE FAX: 866.311.6249
PHONE: 808.599.0215
WWW.ONTHEMOVETHERAPY.COM
OTMTHERAPY@GMAIL.COM

PHYSICAL THERAPY PRESCRIPTION

NAME: _____ PHONE:_____

DIAGNOSIS: _____ICD-9 CODE: _____

☐ EVALUATE AND TREAT

☐ FREQUENCY _____ X A WEEK FOR _____ WEEKS

☐ TREATMENT TO INCLUDE:

- ☐ JOINT / SOFT TISSUE MOBILIZATION
- ☐ RANGE OF MOTION
- ☐ HOME EXERCISE PROGRAM
- ☐ MODALITIES FOR PAIN RELIEF
- ☐ OTHER: _____
- ☐ THERAPEUTIC EXERCISE
- ☐ NEUROMUSCULAR RE-EDUCATION
- ☐ AQUATIC THERAPY
- ☐ BALANCE / STABILIZATION

☐ PRECAUTIONS / RESTRICTIONS: _____

☐ ADDITIONAL ORDERS: _____

_____

_____

PHYSICIAN SIGNATURE: _____DATE:_____

PHYSICIAN NAME PRINTED: _____TEL#: _____

Moving you towards your goals...
... in the comfort and convenience of your home.