REZAC & ASSOCIATES
PHYSICAL THERAPY, LLC
YOU make the CHOICE

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PHYSICAL THERAPY
TREATMENT PRESCRIPTION

PATIENT NAME:_____ DOB: _____
PHONE: _____ WORK PHONE:_____
DIAGNOSIS: _____
PRECAUTIONS / RESTRICTIONS: _____
_____

FREQUENCY AND DURATION:_____ # VISITS:_____

O EVALUATE & TREAT

O PHYSICAL THERAPY EVALUATION
O THERAPEUTIC EXERCISE
O NEUROMUSCULAR RE-EDUCATION
O MANUAL THERAPY
O HOME PROGRAM
O ELECTRICAL STIMULATION
O CRYO / THERMOTHERAPY
O IONTO / PHONOPHORESIS
O ULTRASOUND
O TRACTION
O CANINE ASSISTED THERAPY

O SPINAL STABILIZATION
O GAIT TRAINING
O VESTIBULAR REHABILITATION
O BALANCE TRAINING
O ERGONOMIC ASSESSMENT
O HOME TENS UNIT
O HOME CERVICAL TRACTION
O HOME LUMBAR TRACTION
O LASER THERAPY
O MODALITIES AS INDICATED
O OTHER: _____

_____

I certify the need for these services furnished under this plan of treatment and while under my care.
PHYSICIAN NAME: _____ DATE: _____
PHYSICIAN SIGNATURE: _____ UPIN#: _____

O MD CHECK HERE IF YOU NEED MORE PRESCRIPTION PADS DELIVERED TO YOU

PLEASE VISIT OUR WEBSITE FOR MAP AND PATIENT FORMS
REZACPT.COM