CASCADE
REHABILITATION ASSOCIATES

Physical Therapy Prescription

Patient: ______________________________ Date: ____________

Diagnosis: ______________________________

Precautions / Remarks: ______________________________

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X-ray / Test Results: ______________________________

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Instructions: ❏ **Evaluate and Treat** **Report by:** ❏ Phone ❏ Letter

❏ **Evaluation Only** ❏ **Orthotics** ❏ **Aquatic Therapy**

❏ **Joint Mobilization** ❏ **Vestibular**

❏ **Exercise:** ______________________________

❏ **Modalities:** ______________________________

❏ **Soft Tissue Mobilization:** ______________________________

❏ **Other:** ______________________________

Comments or Special Orders: ______________________________

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Social Services Intervention Needed? ❏ **Yes** ❏ **No**

Treatment Plan: ❏ **Therapist's Discretion**

Frequency/Duration: 1 2 3 4 5 times per week for______ weeks

Additional Comments: ______________________________

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Physician Re-Check Date: ______ **/** ______ **/** ______

Physician's Signature: ______________________________

Thank you for this referral.

12/09