CORE
PHYSICAL THERAPY
Correcting the cause—not just the symptom.

*C*omprehensive *O*rthopedic *R*ehabilitative *E*xercise

Please Fax Prescription to 203 549-0899

Patient Name:_____ **PCP:** _____

Address:_____ **Email:** _____

Phone(H):_____ **(W):**_____ **(C):**_____

Insurance:_____ **Policy #:**_____ **DOB:**_____

Diagnosis:_____ **ICD-9:** _____

Precautions:_____ **Surgical Procedure:**_____ **Surgical Date:** _____

Frequency:_____ **per week/**_____**weeks** **Next Doctor Visit** _____

REHABILITATION PROGRAM

- ❑ **Physical Therapy Evaluation & Treat**
- ❑ **Occupational Therapy Evaluation**
- ❑ **Hand Therapy**
- ❑ **Balance / Vestibular Retraining**
- ❑ **Massage Therapy**
- ❑ **Modalities**
  - ❍ Moist Heat / Cold Packs
  - ❍ Paraffin Bath
  - ❍ Electrical Stimulation/T.E.N.S
  - ❍ Ultrasound / Phonophoresis
  - ❍ Iontaphoresis
  - ❍ Traction (Lumbar / Cervical)
- ❑ **Manual Therapy**
  - ❍ Deep Tissue Massage
  - ❍ Joint Mobilization
- ❑ **Gait Training: Specify**_____
  - ❍ Assistive Device / Brace Evaluation
  - ❍ Orthotic Evaluation/Prescription
- ❑ **Therapeutic Exercises**
  - ❍ Range of Motion- PROM / AAROM / AROM
  - ❍ Stretching Exercises-Location:_____
  - ❍ Progressive Resistive Exercises
  - ❍ Muscle Re-education
  - ❍ Lumbar / Cervical Scapular Stabilization
- ❑ **Patient Education:**
  - ❍ Proprioception/ Kinesthesia Training
  - ❍ Ergonomic Assessment
  - ❍ Postural / Bio-Mechanical Analysis & Retraining
- ❑ **Rehabilitation Programs**
  - ❍ **Osteoporosis** Program
  - ❍ Total Joint Replacement Program
  - ❍ Pre / Post **Pregnancy** Rehabilitation
  - ❍ **Work** Conditioning
  - ❍ Sports Medicine Program
  - ❍ Wellness / Aftercare Program
  - ❍ Diabetic Exercise Prescription

Physician Signature:_____ Date:_____

WWW.MYCOREPT.COM

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