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ACHIEVE
PHYSICAL THERAPY & PERFORMANCE
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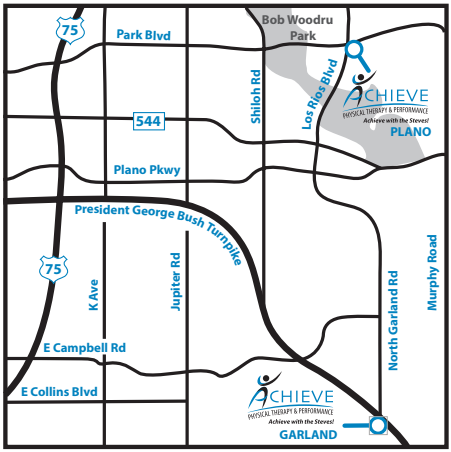

PLANO
2200 Los Rios Blvd. Suite 132, Plano, TX 75074
Tel: 972-509-5070 Fax: 972-509-1557

GARLAND
5255 N. George Bush Hwy, Suite 200
Garland, TX 75040
Tel: 972-881-8887 Fax: 972-730-9887

Patient Name: _____ Phone: _____

Diagnosis: _____

Special Instructions/Precautions: _____

_____

☐ **EVALUATE AND TREAT** ☐ **PLEASE CALL PATIENT TO SCHEDULE**

1◉ 2◉ 3◉ 4◉ 5◉ Times/Week for _____ Weeks

TREATMENT PRESCRIPTION

- ☐ Strengthening
- ☐ ROM
- ☐ Manual Therapy
- ☐ Alter G Anti-Gravity Treadmill
- ☐ Graston Technique
- ☐ Gait Training
- ☐ Work Conditioning
- ☐ Vestibular Rehab

MODALITIES

- ☐ Moist Heat
- ☐ Ultrasound
- ☐ Cryotherapy
- ☐ Cold Laser/Phototherapy
- ☐ Electrical Stim (TENS, NMES, HVGS)
- ☐ Traction/Decompression
- ☐ Iontophoresis/Phonophoresis

TESTING

- ☐ FCE
- ☐ Other

I hereby certify that the above listed physical therapy modalities and procedures are medically necessary for treatment of this patient's diagnosis and condition.

Physician's Signature: _____ Date: _____

(Please attach patient demographics)

DO NOT EMAIL PRESCRIPTION The electronic prescription form is provided for your convenience. With respect to responding to this form, please do not send the prescription via email. Please populate, print and sign a hardcopy so that it may be faxed, mailed or hand delivered to the clinic.