HARTER Physical Therapy

19931 W. Kellogg Suite A **Ph: (316) 550-6132**
Goddard, Ks 67052 **F: (316) 550-6215**

HarterPhysicalTherapy.com
Gabe@HarterPT.com Amanda@HarterPT.com

Outpatient Physical Therapy Prescription

Patient Name: _____

Diagnosis/Surgery: _____

Precautions: _____

☐ **Evaluate and Treat**

Frequency and Duration of Treatment: ☐ **At Therapist's Discretion**

or

_____ times per week for _____ weeks.

Treatment Plan: ☐ **At Therapist's Discretion**

or

☐ Therapeutic Exercise	☐ Manual Therapy	☐ Iontophoresis
☐ Therapeutic Activity	☐ Traction	☐ Prosthetic Training
☐ Neuromuscular Re-Education	☐ Ultrasound	☐ Orthotic Fitting and Training
☐ Gait Training	☐ Electrical Stimulation	☐ Other: _____

Additional Comments/Special Instructions: _____

_____

_____

_____

I certify these services as medically necessary for the patient's plan of care.

Physician's Signature: _____ Date: _____ Time: _____

Printed Name: _____

**Please either provide patient copy of prescription form to bring to first appointment with us, or fax prescription to us prior to patient's initial evaluation.

If required, please specify the preferred contact information to receive communications regarding the progress and plan of care for the above mention patient. _____

_____

_____

Thank you for this referral. Please feel free to contact us any time with questions and comments to further improve our communication with you.