Chronic Pain Recovery Center
25134 Oakhurst Dr. Spring, TX 77386
Phone: (936) 271-0221 Fax: (936) 271-0219
www.chronicpainrecoverycenter.com

Prescription for Physical Therapy

Date: _____

Patient's Name: _____ **DOB:** _____

Phone Number: _____ **DOI (Work Comp.):** _____

ICD-10 Codes: _____

Aquatic/Land Therapy:

- ❒ Evaluate and Treat
- ❒ Aquatic Therapy
- ❒ Land Therapy
- ❒ Therapeutic Exercise
- ❒ Balance/Proprioception Training
- ❒ Myofascial Release/Soft Tissue Mobilization
- ❒ Modalities
- ❒ Neuromuscular Re-Ed
- ❒ Splinting/Taping
- ❒ Patient Education
- ❒ Mechanical Traction
- ❒ Home Exercise Program
- ❒ Therapeutic Activities
- ❒ Gait Training

❒ _____

Precautions: _____

Frequency:

❒ Therapist Discretion OR ❒ _____ x Per Week x _____ Weeks

Improve: ❒ Function/Mobility ❒ Strength ❒ ROM ❒ Flexibility ❒ Endurance ❒ Posture
Decrease: ❒ Pain ❒ Musculoskeletal Tightness ❒ Functional Limitations
Promote: ❒ Ability to return to Work ❒ Health/Physical Well Being ❒ Functional Mobility

Statement of Medical Necessity
I certify that the physical therapy procedures prescribed for this patient are medically and therapeutically necessary, and they require the skills of a licensed physical therapist to:

_____ _____
Referring Physicians Name (Please Print) Phone:

_____ _____
Physicians Signature License Number

Please include demographics and office note for patient to avoid delays in scheduling