4515 OCEAN VIEW BL. SUITE #350
LA CANADA, CA 91011

3000 DOLORES ST.
LOS ANGELES, CA 90065

PH: (818) 369-7620
FAX: (818) 369-7621

PRESCRIPTION FOR PHYSICAL THERAPY

Patient Name:______________________________

Diagnosis: ______________________________

Surgical Procedure: ______________________________

Frequency: ____________ **x/week for** ____________ **weeks**

Specific Instructions:

____

____

____

☐ EVALUATE AND TREAT

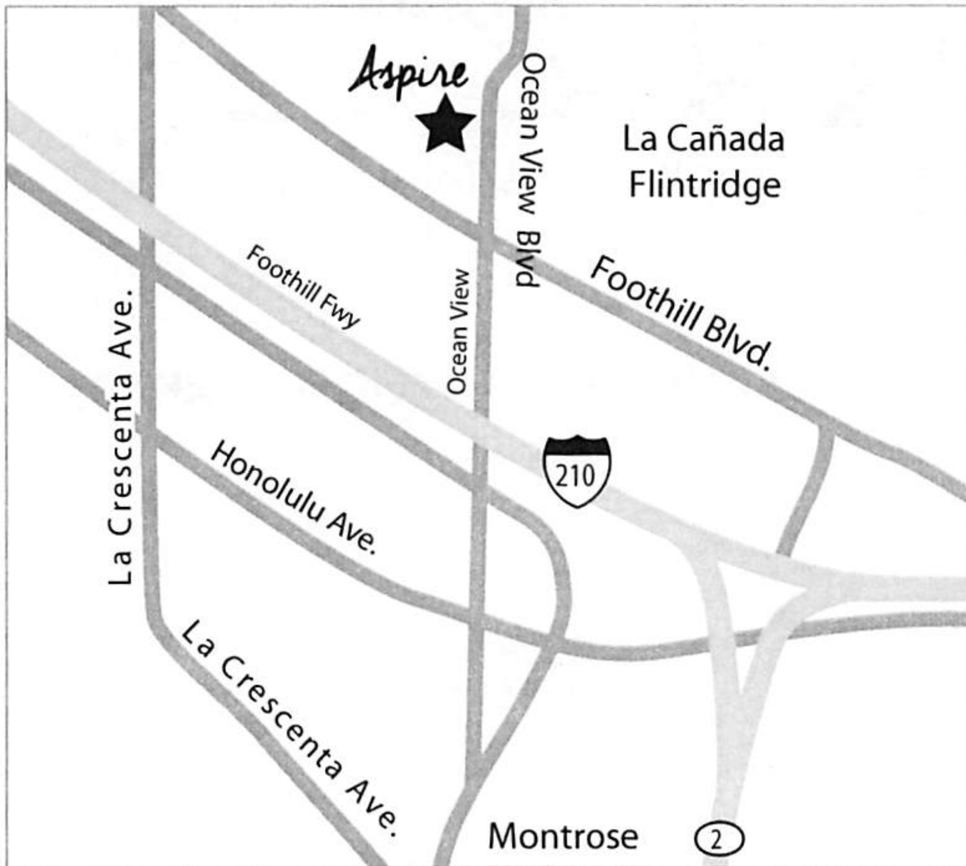
☐ MANUAL THERAPY	☐ GAIT TRAINING
☐ THERAPEUTIC EXERCISE	☐ BALANCE/ FALL PREVENTION
☐ ROM	☐ CORE/ LUMBAR PROGRAM
☐ NEURO RE-EDUCATION	☐ RETURN TO THROWING PROGRAM
☐ MODALITIES	☐ SPORT SPECIFIC TRAINING
☐ HEP/ PATIENT EDUCATION	☐ FUNCTIONAL TRAINING

I hereby certify that I have examined this patient and have determined that Physical Therapy treatments are medically necessary.

Physician Signature: ____________________ **Date** __________

Physician Name:______________________________

Phone Number: ______________________________



4515 OCEAN VIEW BL. SUITE #350 • LA CANADA, CA 91011
PH: (818) 369-7620 • FAX: (818) 369-7621

ELEVATE FITNESS COMPLEX
3000 DOLORES ST. • LOS ANGELES, CA 90065
PH: (818) 369-7620 • FAX: (818) 369-7621