ICONIC WELLNESS
Physical Therapy and Wellness Services
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Physical Therapy Prescription Form

Patient Name:_____ Date of Birth:_____ Sex: ___

Diagnosis: _____ Dx Codes:_____

Special Instructions/Precautions: _____

- **Evaluate and Treat**
- **FREQUENCY AND DURATION 1 2 3 4 5 Times/Week for _____ Weeks**

Treatment Procedures	

• **Therapeutic Exercise**
  • PROM
  • AAROM
  • AROM
• **Therapeutic Activity**
• **Neuromuscular Re-Education**
  • Kinesiotaping
• **Gait Training**
• **Manual Therapy**
  • Dry Needling
  • Dry Cupping
  • Instrument Assisted Soft Tissue Mobilization
	• **Total Joint Rehab**
	• **Posture/Body Mechanics**
	• **Fall Prevention**
	• **Other Protocol: _____**
	• **Home Exercise Program**
	• **Modalities**
	  • **Electrical Stimulation**

This prescription is an evaluate and treat order unless specified otherwise above. I hereby certify that the above listed physical therapy modalities and procedures are medically necessary for treatment of this patient's condition and diagnosis.

Physician Signature: _____ Date: _____

Physician Phone: _____ Physician Fax: _____