PHYSICAL THERAPY PRESCRIPTION

S P A R C

PHYSICAL THERAPY

— PATIENT INFORMATON —

Patient Name: _____

Phone #: _____ Email: _____

— REFERRING DOCTOR INFORMATION —

Referred By: _____

Phone #: _____ Fax #: _____

— REFERRED FOR THE FOLLOWING —

Diagnosis: _____

Special Considerations/Precautions: _____

_____

Goals: _____

_____

TREATMENT FREQUENCY

☐ _____ times a week for _____ weeks.

☐ At Physical Therapist's Discretion

ADDITIONAL COMMENTS/INSTRUCTION

_____

_____

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