BRISTOL REHAB
PHYSICAL THERAPY

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PHYSICAL THERAPY PRESCRIPTION

Patient name: _____ Date of birth: _____

Patient Contact Number: _____ Date of Injury/Surgery: _____

ICD-10: _____ Diagnosis: _____
ICD-10: _____ Diagnosis: _____
Precautions / Comments: _____

Frequency: _____ times per week.
Duration: _____ weeks.
Total visits: _____

□ Physical Therapy Evaluate & Treat.

Manual Therapy	**Therapeutic Exercises**	**Neuromuscular Re-Ed**	**Functional Training**
Joint Mobilization	Strengthening	Posture Education	Gait Training
Myofascial Release	ROM / Flexibility	Ergonomics	Body Mechanics
Soft Tissue Massage	Dynamic Stabilization	Coordination	Balance Training
Manual Traction	Progressive Resistance Exercises	Proprioception	Transfer Training
IASTM (Instrument Assisted Soft Tissue Mobilization)	Muscle Re-Education	Proprioceptive Neuromuscular Facilitation	Bed Mobility
	Home Exercise Program		

Please attach protocol if needed

Anticipated Goals:
□ Decrease Pain □ Increase Strength □ Increase ROM □ Improve Safe Function □ Other

Physician's Signature: _____ Date: _____

Physician's Name (print): _____Phone: _____ Fax: _____