PATRICK J. ZAK. PT

HEIDI J. WYMAN DPT, OCS

PRO-ACTIVE PHYSICAL THERAPY of McCALL, PA

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McCALL, ID 83638
PH: 634-8517 FAX: (208) 292-2817

PHYSICAL THERAPY PRESCRIPTION

PATIENT NAME:_____**DOB:** _____**PH:**_____

DIAGNOSIS:_____**SURGERY (TYPE & DATE):**_____

PRECAUTIONS:_____

ORDERS:

___EVALUATE/TREAT **ICD 10**_____

___THERAPEUTIC EXERCISE (circle type):

Passive Active Isometric Active Assisted Progressive Resistive Other _____

___JOINT MOBILIZATION ____NEUROMUSCULAR REHABILITATION ____GAIT TRAINING

___ULTRASOUND ____ELECTRICAL STIMULATION ____IONTOPHORESIS

___FOOT ORTHOSES___LASER THERAPY

FREQUENCY/DURATION_____

DATE: _____**REFERRING PHYSICIAN:**_____**REFERRING PHYSICIAN:**_____

Print Name Signature