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## PRESCRIPTION

DATE: \_\_\_\_\_ PHYSICIAN \_\_\_\_\_

PATIENT: \_\_\_\_\_

PATIENT PHONE: \_\_\_\_\_

DIAGNOSIS: \_\_\_\_\_

PRECAUTIONS/REMARKS: \_\_\_\_\_

THERAPY ORDERED: \_\_\_\_\_

EVAL AND TREAT: \_\_\_\_\_

Daily \_\_\_\_\_ OR \_\_\_\_\_ times per week for \_\_\_\_\_ weeks.

### HEAT

\_\_\_ Hot Packs  
\_\_\_ Ultrasound

### COLD

\_\_\_ Ice  
\_\_\_ Ice Massage

### TRAINING/EVALUATION

\_\_\_ Indep. Rehab Program  
\_\_\_ Gait Training  
\_\_\_ Stretching  
\_\_\_ General Conditioning  
\_\_\_ Short Toss  
\_\_\_ Long Toss  
\_\_\_ Throwing Mechanics

### EX. PROTOCOLS

\_\_\_ Basic Back  
\_\_\_ Basic Knee  
\_\_\_ Ant. Knee Pain  
\_\_\_ Adv. Closed Chain Knee  
\_\_\_ Basic Shoulder/R.C.  
\_\_\_ C-Spine Ex.  
\_\_\_ Medial/Lateral Epicondylitis  
\_\_\_ Ankle Ex.  
\_\_\_ Lower Extremity Stretching  
\_\_\_ TKR  
\_\_\_ THR  
\_\_\_ TSR

### GENERAL

\_\_\_ Control Swelling  
\_\_\_ Restore ROM  
\_\_\_ Flexibility Training

### EXERCISE EQUIPMENT

\_\_\_ Biodex/Cybex  
\_\_\_ Nautilus  
\_\_\_ Universal  
\_\_\_ UBE (Upper Body Ergometer)  
\_\_\_ Treadmill  
\_\_\_ Ankle Board  
\_\_\_ Stationary Bike  
\_\_\_ Stair Climber  
\_\_\_ Leg Press  
\_\_\_ Hamstring Curl

### MODALITIES

\_\_\_ Iontophoresis \_\_\_\_\_  
\_\_\_ Phonophoresis \_\_\_\_\_  
\_\_\_ Stimulation  
\_\_\_ TENS

### MANUAL THERAPY

\_\_\_ ROM  
\_\_\_ Joint Mobilization  
\_\_\_ Massage  
\_\_\_ Friction Massage  
  
\_\_\_ Post-op Back  
\_\_\_ Post-op Rot. Cuff  
\_\_\_ Post-op Shoulder Instability  
\_\_\_ Post-op ACL  
\_\_\_ Post-op Knee Arthroscopy  
\_\_\_ Post-op Shoulder Arthroscopy

### THERAPEUTIC EXERCISE

\_\_\_ AAROM  
\_\_\_ AROM  
\_\_\_ PROM  
\_\_\_ Resistive Muscle Strengthening  
\_\_\_ Muscle Sets  
\_\_\_ SLR  
\_\_\_ Isometrics  
\_\_\_ Isokinetic  
\_\_\_ Closed Kinetic Chain  
\_\_\_ Theraband/Surg Tubing/Sport Cord  
\_\_\_ Proprioception  
\_\_\_ Rehab. Protocol \_\_\_\_\_

### SPORTS TRAINING

\_\_\_ Preventive Taping  
\_\_\_ Brace Fitting  
\_\_\_ Patella/Ankle Stabilization  
\_\_\_ Brace  
\_\_\_ Motion Studies

### SPINE

\_\_\_ Cervical or Pelvic Traction  
\_\_\_ Back School Programs  
\_\_\_ Massage  
\_\_\_ Friction Massage

**Certification:** I certify that the above-named patient is in need of physical therapy services.

Signature: \_\_\_\_\_