

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Precautions: \_\_\_\_\_

Frequency: \_\_\_\_\_ times per week for \_\_\_\_\_ weeks.

**EVALUATE & TREAT**

- Manual Therapy**
  - Soft Tissue Mobilization
  - Joint Mobilization
  - Myofascial Mobilization
- Therapeutic Exercise**
  - Passive ROM
  - Active ROM
  - Active Assistive ROM
  - Progressive Resistive Exercise
  - Strengthening
  - Stabilization Program
  - Core Strengthening
  - Closed Chain Exercise
  - Posture/Body Mechanics
  - Home Exercise Program
- Sports Specific Training / Rehab**
- Modalities**
  - As Indicated
  - Ultrasound
  - Electrical Stimulation
  - Massage
  - Iontophoresis
  - Phonophoresis
- Neuromuscular Re-education**
  - Balance / Proprioceptive Training
- Gait Training**
- Work Conditioning**
- Post Operative Rehabilitation Protocol for** \_\_\_\_\_  
Date of Surgery \_\_\_\_\_
- Other:** \_\_\_\_\_

**SPECIAL INSTRUCTIONS:** \_\_\_\_\_

\_\_\_\_\_

The above plan of care is established and will be reviewed every 30 days.  
I certify the medical necessity of therapy.

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**DO NOT EMAIL PRESCRIPTION.** The electronic prescription form is provided for your convenience. With respect to responding to this form, please do not send the prescription via email. Please populate, print and sign a hardcopy that may be faxed, mailed or hand delivered to the clinic.



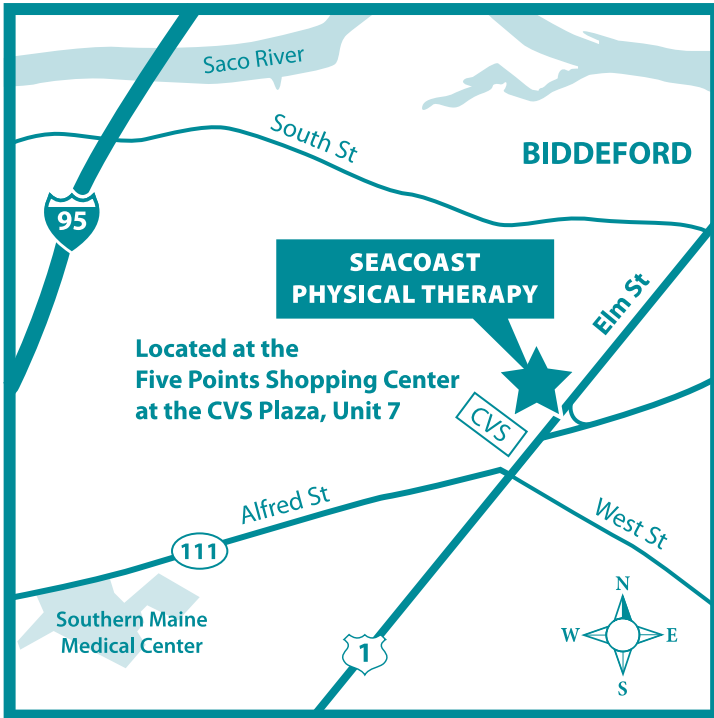
# SEACOAST PHYSICAL THERAPY

[www.SeacoastPTmaine.com](http://www.SeacoastPTmaine.com)

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**Jeff Lebel, P.T./AT,C., M.B.A.**  
Owner / Director

## CONVENIENTLY LOCATED



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### JUST A REMINDER:

- Please bring this referral slip with you on your first visit.
- Please arrive 15 minutes before your scheduled appointment to complete the necessary paperwork.
- The evaluation (1st visit) usually lasts 1 hour.

### WHAT TO WEAR:

- Please wear comfortable clothing.