GRAND OAKS
Sports Medicine & Rehabilitation

28533 Spring Trails Ridge
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Spring, TX 77386
Tel 281-301-5090
Fax 281-651-5259
www.grandoakspt.com

Patient Name: _____ **Date:** _____

Diagnosis: _____

Precautions: _____

Frequency: _____ **times per week for** _____ **weeks.**

EVALUATE & TREAT

- **Therapeutic Exercise**
  - Passive ROM
  - Active ROM
  - Active Assisted ROM
  - Progressive Resistive Exercise
  - Strengthening
  - Stabilization Program
  - Posture/Body Mechanics
  - Gait Training
  - Fall Risk Assessment
  - Home Exercise Program
- **Manual Therapy**
  - Soft Tissue Mobilization
  - Joint Mobilization
  - Myofascial Mobilization
- **Neuromuscular Re-education**
  - Balance/Proprioceptive Training
- **Modalities**
  - Ultrasound
  - Phonophoresis
  - Iontophoresis
  - Electrical Stimulation
  - Mechanical Traction
- **Sports Specific Training**

Other _____

_____

Post Operative Rehabilitation Protocol for _____

Date of Surgery _____

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.

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Grand Oaks Sports Medicine & Rehabilitation is featured on

PTandMe.com

An informational site for patients interested in or considering physical, occupational, and/or hand therapy.