Manual Therapist

PRESCRIPTION

Patient Name _____ Date _____

Date of Injury _____ ID#/DOB _____

A. Diagnosis

(Include ICD-9 codes that specifically address Manual Therapy Treatment)

_____

_____

_____

_____

B. Frequency & Duration

☐ 1× wk for _____ wks
☐ 2× wk for _____ wks
☐ 3× wk for _____ wks
☐ 2× month for _____ months
☐ 1× month for _____ months

C. Medically Necessary Treatment: Implement Plan as Prescribed Below

Application (Primary & Secondary)

☐ Head _____
☐ Neck _____
☐ Chest _____
☐ Shoulders _____
☐ Abdomen _____
☐ Back _____
☐ Lowback/Hips _____
☐ Upper extremities _____
☐ Lower extremities _____
☐ All of the above _____
☐ Other: _____

Treatment Goals

☐ Decrease Pain
☐ Decrease Inflammation
☐ Decrease Muscle Tension/Spasms
☐ Decrease Compensatory Patterns
☐ Increase Mobility
☐ Increase Strength
☐ Restore Function
☐ Restore Posture
☐ Patient Education
☐ All of the Above
☐ Other _____

Specific Instructions/Precautions:

_____

_____

_____

_____

D. Referring Health Care Provider (HCP)

Contact Information

HCP Name _____
Address _____
City _____ State ____ Zip _____
Phone _____
Fax _____
Email _____

Reporting—I will send an initial report after the first visit and a progress report after every 6–8 sessions. Please check how you would like to receive this information:

☐ Fax ☐ Mail ☐ Email
☐ Send Copies of Chart Notes with each report

HCP Signature: _____ Date _____

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