



PHYSICAL THERAPY PRESCRIPTION

Patient Name: _____ Patient D.O.B: _____

Diagnosis (ICD-10 Code): _____

Goals of Rehabilitation to include:

- | | |
|---|---------------------------------------|
| _____ Improved Range of Motion | _____ Improved Posture / Biomechanics |
| _____ Improved Gait | _____ Improved Functional Ability |
| _____ Increased Strength | _____ Improved Motor Planning |
| _____ Improved Midline Orientation | _____ Improved Balance |
| _____ Establish / Upgrade Home Exercise Program | |

Frequency: _____ 1-2x/week _____ Duration: _____ 1 Year _____

Comments/Recommendations: _____

Date: _____

Physician Signature: _____

Physician Name: _____

Address: _____

Telephone #: _____ Fax #: _____

WARNING: UNDER TEXAS LAW (CHAPTER 87, CIVIL PRACTICE & REMEDIES CODE) A FARM ANIMAL PROFESSIONAL IS NOT LIABLE FOR AN INJURY TO OR THE DEATH OF A PARTICIPANT IN FARM ANIMAL ACTIVITIES RESULTING FROM THE INHERENT RISKS OF FARM ANIMAL ACTIVITIES.