



ROCKY MOUNTAIN PHYSICAL THERAPY

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Fax: (970)460-0136

To:	From:
Fax:	Pages:
Phone:	Date:
Re:	CC:

Notes/Comments:

PHYSICAL THERAPY PRESCRIPTION

Name: _____ Date: _____

Diagnosis / ICD-9: _____

Comments / Precautions: _____

Evaluate and Treat as Appropriate

Services:

- | | |
|---|---|
| <input type="checkbox"/> Strength / ROM / Stretching | <input type="checkbox"/> Aquatic (Pool) Therapy (Fort Collins Only) |
| <input type="checkbox"/> Aerobic / Endurance Conditioning | <input type="checkbox"/> ADL / Safety / Assistive Device Training |
| <input type="checkbox"/> Therapeutic Activities | <input type="checkbox"/> Gait / Balance Training |
| <input type="checkbox"/> Manual Therapy | <input type="checkbox"/> Home Exercise Program / Gym Program |
| <input type="checkbox"/> Neuromuscular Retraining | <input type="checkbox"/> Cardiopulmonary Therapy Program |
| <input type="checkbox"/> KinesioTaping | <input type="checkbox"/> Balance /Falls Program |
| <input type="checkbox"/> Ultrasound / NMES / TNS | <input type="checkbox"/> Weight Management Program |
| <input type="checkbox"/> Pilates Core Stabilization | <input type="checkbox"/> Diabetic Therapy Program |

Summit Back Brace

Number of Visits: _____

In making this referral, physician certifies that prescribed rehabilitation is a medical necessity.

Physician Signature (required): _____

Print Name: _____

Please fax to (970)460-0136

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