PHYSICAL THERAPY PRESCRIPTION

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DATE: _____

PATIENT NAME: _____

D.O.B: _____ MRN: _____

DIAGNOSIS: HIP _____
❒ Right ❒ Left ❒ Bilateral

___ Ice / Massage / Anti-Inflammatory Modalities

___ Range of Motion ❒ Active ❒ Active-Assisted ❒ Passive

___ Active Release Therapy/Manual Therapy

___ Gluteus Maximus/Iliopsoas/Adductor/Abductor stretching and strengthening

___ Quadriceps and Hamstring stretching and strengthening

___ Iliotibial Band Stretching / Strengthening

___ Straight Leg Raises / Quad Isometrics

___ Exercise Bike ___ Stairclimber / elliptical ___ Cybex

___ Hydrotherapy

___ Other: _____

Treatment: ❒ Eval and Treat or ❒ 1 ❒ 2 ❒ 3 times per week

Duration: ❒ 4 ❒ 6 weeks

❒ Home Program

**Please send progress notes.

Physician's Signature**:** _____

NPI #: 1164790507