

PHYSICAL THERAPY PRESCRIPTION

Jeffrey Wong, MD

SCOS Orthopedic Specialists
18785 Brookhurst Street, Ste 100
Fountain Valley, CA 92708
(714) 500-5056 Phone
(949) 900-2116 Fax

DATE: _____

PATIENT NAME: _____

D.O.B: _____ MRN: _____

DIAGNOSIS: _____

___ Ice / Massage / Anti-Inflammatory Modalities

___ Range of Motion Active Active-Assisted Passive

___ Quadriceps and Hamstring stretching

___ Quadriceps Strengthening ___ V.M.O. Strengthening

 ___ Full Arc ___ 0-30° Arc

___ Hamstring Strengthening

___ Iliotibial Band Stretching / Strengthening

___ Adductor/Abductor Stretching / Strengthening

___ Straight Leg Raises / Quad Isometrics

___ Exercise Bike ___ Stairclimber ___ Cybex

___ Achilles Tendon Stretching

___ Medial Patella Glides

___ Electrical Stimulation for Quadriceps

___ 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