

PHYSICAL THERAPY PRESCRIPTION

Jeffrey Wong, MD

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DATE: _____

PATIENT NAME: _____

D.O.B: _____ MRN: _____

DIAGNOSIS: SHOULDER DEGENERATIVE JOINT DISEASE

Right Left Bilateral

Range of Motion Active Active-Assisted Passive

Rotator Cuff, Deltoid strengthening program

Scapular stabilization program

Modalities PRN - Ultrasound / Phonophoresis / E-stim / Moist Heat / Ice

___ 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