

# PHYSICAL THERAPY PRESCRIPTION

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DATE: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

D.O.B: \_\_\_\_\_ MRN: \_\_\_\_\_

DIAGNOSIS: CERVICAL RADICULOPATHY / DDD

Cervical Stabilization program

Flexibility / Strengthening / Endurance

Postural Exercises

Trapezius, Levator, Scapulae, Rhomboid, Scapular Stabilizer strengthening

Modalities as needed (Ultrasound / Phonophoresis / E-stim)

\_\_\_ 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