PHYSICAL THERAPY PRESCRIPTION

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DATE: ______________________

PATIENT NAME: ____

D.O.B: ______________________ **MRN:** ______________________

DIAGNOSIS: ANKLE FRACTURE - ❒ Medial Malleolus ❒ Lateral Malleolus ❒ Bimalleolar
❒ Right ❒ Left ❒ Bilateral
SURGERY: ANKLE ORIF
DATE OF SURGERY: ___________

Weightbearing status**:** ❒ NWB ❒ PWB ❒ WBAT

___ Ice Massage / Ice Bath / Whirlpool

___ Anti-Inflammatory Modalities

___ Range of Motion Active / Active-Assisted / Passive

___ Flexibility

___ Compression – Aircast / Jobst Intermittent Compression

___ Isometrics for Inversion / Eversion – Progress to Isokinetics and Isotonics

___ Isotonics for Plantar / Dorsiflexion

___ Proprioception training, BAPS

___ Advance to Lateral step-ups, Sport-cord, Euroglide

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