PHYSICAL THERAPY PRESCRIPTION

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DATE: _____

PATIENT NAME: _____

D.O.B: _____ **MRN: _____**

DIAGNOSIS: HIP FRACTURE – ❒ FEMORAL NECK ❒ INTERTROCH ❒ SUBTROCH
❒ Right ❒ Left ❒ Bilateral
SURGERY: _____
DATE OF SURGERY: _____

Weightbearing status: ❒ NWB ❒ PWB ❒ WBAT

___ Hip ROM

Posterior hip precautions for hemiarthroplasty / total hip arthroplasty

___ Hip strengthening program

___ Gait training

___ Wean from crutches / walker

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