



NORTHERN OAKS Orthopedic and Sports PHYSICAL THERAPY

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Patient Name: _____ Date: _____

Diagnosis: _____

Precautions: _____

Frequency: _____ times per week for _____ weeks.

EVALUATE & TREAT

Therapeutic Exercise

- Passive ROM
- Active ROM
- Active Assisted ROM
- Progressive Resistive Exercise
- Strengthening
- Stabilization Program
- Posture/Body Mechanics
- Gait Training
- Home Exercise Program

Manual Therapy

- Soft Tissue Mobilization
- Joint Mobilization
- Myofascial Mobilization

Post Operative Rehabilitation Protocol for _____

Date of Surgery _____

Neuromuscular Re-education

- Balance/Proprioceptive Training

Modalities

- Ultrasound
- Phonophoresis
- Iontophoresis
- Electrical Stimulation
- Mechanical Traction

Sports Specific Training

Other _____

SPECIAL INSTRUCTIONS: _____

The above plan of care is established and will be reviewed every 30 days.
I certify the medical necessity of therapy.

Physician's Signature: _____

Date: _____

DO NOT EMAIL PRESCRIPTION The electronic prescription form is provided for your convenience. With respect to responding to this form, please do not send the prescription via email. Please populate, print and sign a hardcopy that may be faxed, mailed or hand delivered to the clinic.



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Northern Oaks Orthopedic and Sports Physical Therapy is featured on

PTandMe.com

*An informational site for patients interested in or considering
physical, occupational, and/or hand therapy.*