SUMMIT PHYSICAL THERAPY

The leaders in personalized, hands-on care.

www.summitptofwv.com

Patient Name: _

Precautions: Frequency:	Diagnosis:		
Manual Therapy	Precautions:		
□ Manual Therapy □ Sports Specific Training / Rehab □ Soft Tissue Mobilization □ Modalities □ Joint Mobilization □ Moist Heat □ Whirlpool □ Ultrasound □ Joint/Spinal manipulation □ Electrical Stimulation □ Dry Needling □ Assage □ Passive ROM □ Massage □ Active ROM □ Neuromuscular Re-education □ Active Assistive ROM □ Balance / Proprioceptive Training □ Progressive Resistive Exercise □ Stabilization Program □ Gait Training □ Core Strengthening □ Work Conditioning □ Certified Hand Therapy (Weirton and Peter's) □ Closed Chain Exercise □ Posture/Body Mechanics □ Therefore The Post Operative Rehabilitation Protocol for Date of Surgery □ Bracing/Orthotic Fabrication & Fitting: □ Other: The above plan of care is established and will be reviewed every 30 days. I certify the medical necessity of therapy.	Frequency:	_ times per week for weeks.	
Soft Tissue Mobilization	■ EVALUATE & TREAT		
Date of Surgery	□ Soft Tissue Mobilization □ Joint Mobilization □ Myofascial Mobilization □ Whirlpool □ Joint/Spinal manipulation □ Dry Needling □ Therapeutic Exercise □ Passive ROM □ Active ROM □ Active ROM □ Progressive Resistive Exercise □ Strengthening □ Stabilization Program □ Core Strengthening □ Closed Chain Exercise □ Posture/Body Mechanics	 Modalities Moist Heat Ice Ultrasound Electrical Stimulation Massage Iontophoresis Neuromuscular Re-education Balance / Proprioceptive Training Gait Training Work Conditioning 	
□ Bracing/Orthotic Fabrication & Fitting: □ Other: □ SPECIAL INSTRUCTIONS: □ The above plan of care is established and will be reviewed every 30 days. I certify the medical necessity of therapy.			
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Physician's Signature: Date:			
	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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CHESTER

118 Carolina Avenue Chester, WV 26034

P: 304-387-4110 F: 304-387-4112

FOLLANSBEE

1425 Main Street Follansbee, WV 26037

P: 304-527-4472 F: 304-527-4648

MCMURRAY

100 Wilhaven Drive, Ste. 100 McMurray, PA 15317

P: 724-941-3727 F: 724-941-3761

NEW CUMBERLAND

621 N Chester Street New Cumberland, WV 26047

P: 304-564-1098 F: 304-564-5020

WEIRTON

414 Penco Road Weirton, WV 26062 P: 304-723-3780

F: 304-723-4110

JUST A REMINDER:

- Please bring this referral slip with you on your first visit.
- Please arrive 30 minutes before your scheduled appointment to complete the necessary paperwork.
- The evaluation (1st visit) usually lasts 1 hour.

WHAT TO WEAR:

· Please wear comfortable clothing based upon your condition.