StableMovement Physical Therapy, 3630 Deedham Drive, San Jose, CA 95148.
☎ (408)252-8790. Website: www.stablemovement.com

Prescription for Physical Therapy Outpatient Services

Patient Name: _____ DOB: _____

Patient Address: _____

Patient Contact #: Home: _____Cell:_____

Physician (PCP):_____PCP phone #: _____

Referring MD: _____ Phone #:_____

Diagnosis/ICD-9 code/ICD-10 code: _____

Please check one: ☑

Initial Physical Therapy Evaluation ☐ **Continue Physical Therapy Services ☐**

Frequency of Treatment: (please circle)
1 2 3 4 5 visits/week

Duration of PT: (please circle)
1 2 3 4 5 6 7 8 weeks

EVALUATE & TREAT:	PLAN:	COMMENTS
☐ Ankle and Foot	☐ Manual Therapy	
☐ Knee	☐ Therapeutic Exercises	
☐ Hip	☐ Strengthening/ Conditioning	
☐ Low Back/Lumbar Spine	☐ Stretching/ Flexibility	
☐ Mid-back/Thoracic Spine	☐ Endurance	
☐ Neck/ Cervical Spine	☐ Posture Education/Training	
☐ Shoulder	☐ Balance Activities	
☐ Elbow//Forearm	☐ Gait Training	
☐ Wirst/Hand	☐ Moist Heat/ Cold Pack	
☐ Body Mechanics/Fitness Eval	☐ Bracing/ Taping	
☐ Wellness	☐ Home Program	

I acknowledge the benefit/ need for above-mentioned physical therapy outpatient services for my patient Ms/Mr/Mrs _____ while under my care.

Physician Signature: _____ Date: _____