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Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Diagnosis / Procedure: \_\_\_\_\_

Precautions or Specific Requests: \_\_\_\_\_

WT. BEARING STATUS:	<input type="checkbox"/> Full	<input type="checkbox"/> Toe	<input type="checkbox"/> Touch	<input type="checkbox"/> Partial _____%	<input type="checkbox"/> NWB
MEDICAL INFORMATION:	<input type="checkbox"/> ↓ Swelling	<input type="checkbox"/> ↑ ROM			
	<input type="checkbox"/> Pre op	<input type="checkbox"/> Post op	<input type="checkbox"/> Pain Level: 1 2 3 4 5 6 7 8 9 10		
WORK STATUS:	<input type="checkbox"/> Full Duty	<input type="checkbox"/> Light Duty	<input type="checkbox"/> None		

**EVALUATE & TREAT**

**TREAT ONLY AS SPECIFIED BELOW**

**MANUAL THERAPY**

- Soft Tissue
- Joint Mobilization
- Manual Traction
- Myofascial Release
- Scar Mobilization

**MODALITIES**

- Cold Pack/ Moist Heat
- Ice Massage
- Paraffin Bath
- Electrical Stimulation
- Neuromuscular Re-education
- Gait Training
- Ultrasound
- Iontophoresis (*medication Rx required*)
- Phonophoresis
- T.E.N.S. (*Rental / Purchase*)
- N.M.E.S. (*Rental / Purchase*)

**THERAPEUTIC EXERCISE**

- Passive ROM
- Active Assistive ROM
- Active ROM
- Resistive
- Isometric

**HOME EXERCISE PROGRAM**

- Flexibility/ Stretching
- Isometrics
- Strengthening
- Theraband
- Pre Op/Post Op Program

**PROTOCOLS**

- Shoulder
- Elbow
- Wrist
- Hip
- Knee
- Ankle
- Foot
- Back
- Neck
- Balance Training
- Gait Training
- Spinal Stabilization
- McKenzie Rehab
- Patellofemoral
- McConnell Taping

FREQUENCY:  1 x weekly     2 x weekly     3 x weekly     Daily  
 DURATION:  1 week     2 weeks     3 weeks     4 weeks

THIS PRESCRIPTION IS AN EVALUATE AND TREAT ORDER UNLESS SPECIFIED ABOVE.

I CERTIFY THAT THE ABOVE TREATMENT PLAN IS MEDICALLY NECESSARY AND IS APPROVED.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_