

PHYSICAL THERAPY PRESCRIPTION



**Physical Therapy
Sports Rehabilitation, LLC**

Debra J. Layne, PT
Ted Layne, PT, ATC
Nicole L. Peskin, PT
Laura Shove, MS, PT
Denise Baugh, MS, PT
Becky Rippel, PT
Kasey O'Leary, MS, PT
Ed Peskin, PT
Don Gallotte, MS, ATC

Laura Zaruba, CMT
Jennifer Schaub, MPT
Mary White, MPT, ATC
Mary Ewers-Dennison, OTR, CHT
Terri Handy, MS, PT
Lee Brennan, MS, PT
Michele McCarthy, MSPT
Beth Malecki, ATC
Jill Van Dyke, CMT

Patient _____

Diagnosis _____

Recent Surgery _____

Precautions _____

RX:

- | | |
|--|--|
| <input type="checkbox"/> Evaluation and Treatment | <input type="checkbox"/> Pain Management |
| <input type="checkbox"/> Home Program and Education | <input type="checkbox"/> Certified Hand Therapy |
| <input type="checkbox"/> Pre-op/Post-op Rehab | <input type="checkbox"/> Worksite Eval. |
| <input type="checkbox"/> ROM and Strengthening | <input type="checkbox"/> Custom Orthotics |
| <input type="checkbox"/> Whirlpool/Wound Care | <input type="checkbox"/> Brace/Splint |
| <input type="checkbox"/> Certified Vestibular Rehab | <input type="checkbox"/> Pre & Post-natal Ex. |
| <input type="checkbox"/> TMJ or Headache RX | <input type="checkbox"/> Pelvic Floor Rehab |
| <input type="checkbox"/> Arthritis RX | <input type="checkbox"/> Incontinence Program |

Other _____

Frequency: _____ **by Physical Therapist's treatment plan**

OR _____ **times per week for** _____ **weeks.**

Signature _____ **Date** _____

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