

# PREHAB USA

## PREHAB PRESCRIPTION/CONSULTATION AND TREATMENT REQUEST

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Pre-surgery Dx: \_\_\_\_\_

Procedure: \_\_\_\_\_

Orthopedic Precautions:

\_\_\_\_\_  
\_\_\_\_\_

Medical Precautions:

\_\_\_\_\_  
\_\_\_\_\_

Physical Therapy evaluation and education of strength, aerobic fitness, flexibility with development of wellness/fitness program to be done preoperatively to joint surgery or as a preventative method.

I certify that I have examined this patient and the above evaluation and subsequent wellness/fitness program is necessary and that services will be furnished while the patient is under my care; and that the plan is established and will be reviewed every 30 days or more often if the patient's condition requires.

Referring physician's name: \_\_\_\_\_ NPI# \_\_\_\_\_

Office's Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

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