VITAL PHYSICAL THERAPY

INTEGRATIVE HANDS-ON THERAPY

Physical Therapy Prescription

Date: _____

Pt's name: _____ Pt's phone number:_____

Diagnosis:_____

Treatment frequency _____ times per week Duration _____ weeks

- ☐ Evaluate and treat
- ☐ Manual Therapy
- ☐ Pilates for Rehabilitation
- ☐ Kinesiotaping
- ☐ Other:
- ☐ Pre/Post Surgical Rehab
- ☐ Trigger point dry needling
- ☐ Yoga Therapy
- ☐ Custom Orthotics

_____ _____

Name of Referral (please print) Signature

_____ _____

Referring phone number Referring fax number

Located inside Red Rocks Medical Center
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