REVELLE

PHYSICAL THERAPY

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PHYSICAL THERAPY PRESCRIPTION

Name: ________________________________ DOB: __________________

Physician Name: ____

Diagnosis: ____

Precautions/Comments: _______________________________________

☐ EVALUATE AND TREAT

- ☐ Abdominal Pain
- ☐ Abdominal Adhesions
- ☐ Constipation
- ☐ Coccyx Pain
- ☐ Diastasis Recti
- ☐ Dyspareunia
- ☐ Headaches
- ☐ Low Back/Hip/Groin Pain
- ☐ Muscle Weakness
- ☐ Pelvic Organ Prolapse
- ☐ Sacroiliac Joint Dysfunction
- ☐ Sciatica
- ☐ Symphysis Pubis Dysfunction
- ☐ Urinary Frequency
- ☐ Urinary/Stress Incontinence
- ☐ Vulvodynia
- ☐ Other: ____

I hereby certify that Physical Therapy is medically necessary for this patient's plan of care.

_____________________________________ ____________________

Physician's Signature Date