

revelle

PHYSICAL THERAPY

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PHYSICAL THERAPY PRESCRIPTION

Name: _____ DOB: _____

Referring provider: _____

Diagnosis: _____

Precautions/comments: _____

- | | |
|---|---|
| ☐ Evaluate & treat | |
| ☐ Internal pelvic floor muscle assessment | |
| ☐ Trigger point dry needling with/without e-stim | |
| ☐ Abdominal pain | ☐ Pelvic floor muscle weakness |
| ☐ Constipation | ☐ Pelvic pain |
| ☐ Coccydynia | ☐ Pudendal neuralgia |
| ☐ Diastasis recti | ☐ Sacroiliac joint dysfunction |
| ☐ Dyspareunia | ☐ Sciatica |
| ☐ Endometriosis/adenomyosis | ☐ Symphysis pubis dysfunction |
| ☐ Headaches | ☐ Urinary frequency |
| ☐ Low back/hip/groin pain | ☐ Urinary/stress incontinence |
| ☐ Muscle weakness | ☐ Vaginismus |
| ☐ Pelvic organ prolapse | ☐ Vulvodynia/vestibulodynia |
| ☐ Painful bladder syndrome/IC | ☐ Other _____ |

I certify that physical therapy is medically necessary for this patient's plan of care.

Referring provider

Date