

revelle

PHYSICAL THERAPY

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PHYSICAL THERAPY PRESCRIPTION

Name: _____ DOB: _____

Physician Name: _____

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 | |

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

Physician's Signature

Date