NJ KNEE AND SHOULDER CARE P.C.

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Palisades Park, New Jersey 07650
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PHYSICAL THERAPY PRESCRIPTION

NAME : _____ DATE OF REFERRAL: _____

DATE OF BIRTH :_____

DIAGNOSIS: _____

SPECIFIC INSTRUCTIONS (AS NEEDED): _____

- ☐ Evaluate & Treat
- ☐ Home Safety Evaluation
- ☐ Home Equipment/ Modification Assessment and Training
- ☐ Modalities
  - ☐ Hot / Cold Packs
  - ☐ Electrical Stimulation
  - ☐ Vasopneumatic Device
  - ☐ Ultrasound
  - ☐ Paraffin
  - ☐ Traction
- ☐ Therapeutic Exercise
  - ☐ Range of Motion
  - ☐ Strengthening
  - ☐ Stretching
- ☐ Neuromuscular Re-Education
- ☐ Gait Training
- ☐ Massage/ Soft Tissue Work
- ☐ Manual Therapy / Joint Mobilization
- ☐ Kinetic/ Therapeutic Activities
- ☐ Home Exercises

GOALS:
Improve ROM
Improve Strength
Improve Mobility
Improve Function

_2-3_ Number of Visits Per Week

_4-6_Weeks (Treatment Duration)

ANJANI SINHA, M.D.