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NEWPOINT
PHYSICAL THERAPY SERVICES INC

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Physical Therapy Prescription:

- Patient name:_____
- Date:_____
- Diagnosis/ICD-9:_____
- Precautions/Comments:_____
- Services (please check):
  - Strength/ROM/Stretching
  - Stabilization
  - Education/Home Exercises Program
  - Balance/gait
  - Manual Therapy
  - Mechanical Traction: cervical/lumbar
  - Vestibular Rehab
  - Pelvic Floor
  - Other:_____

Number of visits: _____
Physician Signature (required):_____
Physician Name (required): _____

Thank you for your referral