

Dinah L. Pesnell, PT, DPT, MTC

Owner / Director

Patient Name:	Date:	
Diagnosis:		
Precautions:		
Frequency:	times per week for	weeks.
EVALUATE & TF	REAT	
 Manual Therapy Soft Tissue Mobilization Joint Mobilization Myofascial Mobilization Therapeutic Exercise Passive ROM Active ROM Active Assistive ROM Progressive Resistive Exercise Strengthening Stabilization Program Core Strengthening Closed Chain Exercise Posture/Body Mechanics Home Exercise Program 	 Sports Specific Training / R Modalities Moist Heat Ice Ultrasound Electrical Stimulation Massage Iontophoresis Phonophoresis Vasopneumatic Compression Intermittent Compression Neuromuscular Re-educati Balance / Proprioceptive T Gait Training Work Conditioning 	sion/lce n Pump (GameReady) on Fraining
Post Operative Rehabilitation Proto		
Date of Bracing/Orthotic Fabrication & Fit Other:		

SPECIAL INSTRUCTIONS:_

The above plan of care is established and will be reviewed every 30 days. I certify the medical necessity of therapy.

Physician's Signature:

DO NOT EMAIL PRESCRIPTION The electronic prescription form is provided for your convenience. With respect to responding to this form, please do not send the prescription via email. Please populate, print and sign a hardcopy that may be faxed, mailed or hand delivered to the clinic.

Date:

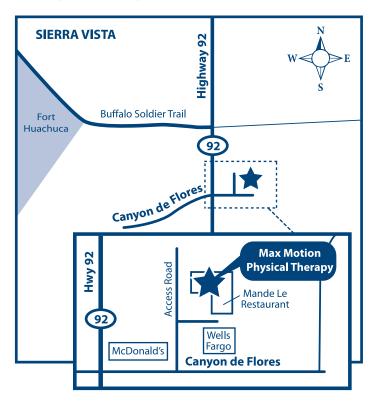


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DIRECTIONS:

- Turn east at the light on Highway 92 and Canyon de Flores.
- Turn north on the access road behind McDonald's.
- Max Motion Physical Therapy is next door to Mande Le Restaurant.



JUST A REMINDER:

- Please bring this referral slip with you on your first visit.
- Please arrive 15 minutes before your scheduled appointment to complete the necessary paperwork.
- The evaluation (1st visit) usually lasts up to 1 hour. WHAT TO WEAR:
- Please wear comfortable clothing.