EL PASO
MANUAL PHYSICAL THERAPY

Phone: (915) 503-1314
Fax: (915) 255-3826

Prescription for Physical Therapy

Patient Name: _____

Diagnosis: _____

_____

Precautions:_____

_____

Special Instructions: _____

_____

_____

_____

Frequency _____/Week **Duration**_____weeks

☐ Treatment as Indicated by Physical Therapist

Provider Signature _____ Date_____

Provider Fax Number _____

"I certify/recertify the need for these services furnished under this plan of treatment and while under my care"