RESPONSE PHYSICAL THERAPY

ORDERS

Patient Name: _____

Phone: _____

Diagnosis: _____

Precautions: _____

EVALUATE AND TREAT

MANUAL THERAPY

Traction
Joint Mobilization
Soft Tissue Mobilization
Stretching

THERAPEUTIC EXERCISE

Passive ROM
Active Assisted / Active ROM
Strengthening
Core Stabilization
Proprioceptive Training

MODALITIES

Moist Heat / Ice
Ultrasound
Iontophoresis
Dosage _____
Electrical Stimulation

Other _____

Frequency _____times / week **Duration** _____times / week

I certify that this patient is under my care and requires physical therapy treatment as prescribed above.

Physician's Name: _____

Signature: _____

Office Phone: _____

Phone: 919.678.3286
Fax: 919.999.2488
www.responsetherapy.com

107 Edinburgh S Dr #100a
Cary, NC 27511