



Aurora, Crest Hill, Homer Glen, Joliet,  
Naperville – South, Plainfield, Willowbrook

Phone: 815-836-3799 Fax: 815-836-8799  
www.advPhysicians.com  
info@advPhysicians.com

## Physical Therapy Services Rx

Patient Name:  DOB:

Diagnosis:  Date:

### Physical Therapy orders:

- Evaluate and treat
- Evaluate ASAP (24-48 hrs)

- Work Conditioning Program
- Pre/Post Op Protocol
- Postural Program
- Lumbar Stabilization
- PROM/AROM/AAROM/Flexibility
- Strengthening / PRE's
- Soft Tissue/Joint Mobilization
- Balance/Fall Prevention
- Gait training/Running Analysis
- Electrical Muscle Stimulation

### Massage Therapy:

- Recommended

### Personal Training:

- Recommended

- Myofascial/Trigger Point Therapy
- Traction: Cervical / Lumbar
- Trigger Point Therapy
- Home Exercise Program
- Custom Foot Orthotics
- Sports Rehab Program
- Modalities (prn)
- Concussion Rehab
- Headache Program
- Dry Needling

Special Considerations:

Frequency:  1  2  3 times a week for  weeks

Physician Name (print)

Physician Signature

In making this referral, the physician certifies that the prescribed care is medically indicated.

Your Physician Has Prescribed Physical Therapy

**Now What?**

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