Xcel SPORTSMEDICINE
HANDS-ON PHYSICAL THERAPY

PHYSICAL THERAPY PRESCRIPTION

Patient's Name _____ Phone Number _____

Diagnosis _____ ICD10 Code _____

Contraindictions/Weight Bearing Status _____

_____

_____

Frequency/Duration _____ per week x _____weeks

Evaluate and Treat _____

Special Request _____

Comments _____

_____

_____

_____

I certify _____, re-certify _____, that I have examined the patient and physical therapy is medically necessary.

Physician's Signature _____ Date _____

Xcel SPORTSMEDICINE
HANDS-ON PHYSICAL THERAPY

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