PROTHERAPY CONCEPTS, INC
OUTPATIENT PHYSICAL THERAPY
MOBILE AND IN-OFFICE

Debbie Dabbs, PT, DPT, M.Ed
D. Stacey Styons, PT
Brittany Rumley, PTA

723 S. Van Buren Road Suite C
Eden, NC 27288
Phone (336) 627-7398
Fax (336) 900-6795 KfAX (949) 561-4142

PHYSICAL THERAPY PRESCRIPTION/REFERRAL

SERVICE LOCATION:

___IN CLINIC ___IN PATIENT HOME ___AT PATIENT DISCRETION

Patient: _____ DOB: _____
Diagnosis: _____
Provider: _____ Date: _____

Order for:

___ PHYSICAL THERAPY EVAL AND TREAT
___ CONTINUATION OF THERAPY FOR _____(duration)

Duration: (If specified)

___ TIMES PER WEEK FOR ___ WEEKS

L**imitations/Restrictions/Precautions**:

_____

Weight Bearing Restrictions (please note if applicable)
No Restrictions WBAT %____ TTWB____ NWB____

INTERVENTIONS:

Please circle for specific request/order IF INDICATED, otherwise Eval/Treat meets requirements

AROM/AAROM/PROM	GAIT TRAINING	VESTIBULAR REHAB
MANUAL THERAPY	NEURO REHAB	SPORT SPECIFIC REHAB
MODALITIES	STRENGTHENING	PELVIC FLOOR THERAPY
COLD/HOT PACKS		
ULTRASOUND	HOME EXERCISE PROG.	DRY NEEDLING
E-STIM		
LASER	BALANCE TRAINING/	
KINESIOTAPING	FALL RISK REDUCTION	

OTHER: _____

PROVIDER SIGNATURE _____
DATE: _____

THANKS FOR THE REFERRAL!
Please include patient demographics with referral.