



6318 FM 1488, Suite 150
Magnolia, TX 77354
Tel 936-273-0808 • Fax 936-273-0860
www.westwoodlandspt.com

18001 Highway 105, Suite 106
Montgomery, TX 77356-2881
Tel 936-582-2464 • Fax 936-582-4697
www.lakeconroeptandsports.com

Patient: _____ Date: _____

Phone: (Home) _____ (Mobile) _____

Diagnosis: _____

Frequency: _____ times per week Duration: _____ weeks or _____ visits

Evaluate & Treat *Check All Boxes That Apply*

Exercise	Manual Therapy	Modalities
<input type="checkbox"/> PROM <input type="checkbox"/> AAROM <input type="checkbox"/> AROM <input type="checkbox"/> Strengthening <input type="checkbox"/> Flexibility <input type="checkbox"/> Posture Retraining <input type="checkbox"/> Gait Training (Device _____) WB Status _____	<input type="checkbox"/> Joint Mobilization <input type="checkbox"/> Traction (Cervical or Pelvic) <input type="checkbox"/> Soft Tissue Mobilization <input type="checkbox"/> Proprioceptive Neuromuscular Facilitation <input type="checkbox"/> Therapeutic Massage <input type="checkbox"/> Myofascial Release	<input type="checkbox"/> Electrical Stimulation <input type="checkbox"/> Iontophoresis <input type="checkbox"/> Ultrasound <input type="checkbox"/> Hot/Cold Packs <input type="checkbox"/> NMES <input type="checkbox"/> EMG
Specialized Services	Home Programs	Other
<input type="checkbox"/> McKenzie Intervention <input type="checkbox"/> Spine Stabilization <input type="checkbox"/> Sport Specific Training <input type="checkbox"/> Sports Rehab <input type="checkbox"/> Neuromuscular Re-Ed	<input type="checkbox"/> Home Exercise Program <input type="checkbox"/> Home Traction Cervical/ Lumbar <input type="checkbox"/> TENS/IFC Rental <input type="checkbox"/> NMES Rental <input type="checkbox"/> EMG Rental	_____ _____ _____ _____

Special Instructions/Precautions:

I certify that the above ordered treatment for therapy is medically necessary.

Physician Signature _____ Date _____

Return to Physician Date _____

DO NOT EMAIL PRESCRIPTION The electronic prescription form is provided for your convenience. With respect to responding to this form, please do not send the prescription via email. Please populate, print and sign a hardcopy that may be faxed, mailed or hand delivered to the clinic.



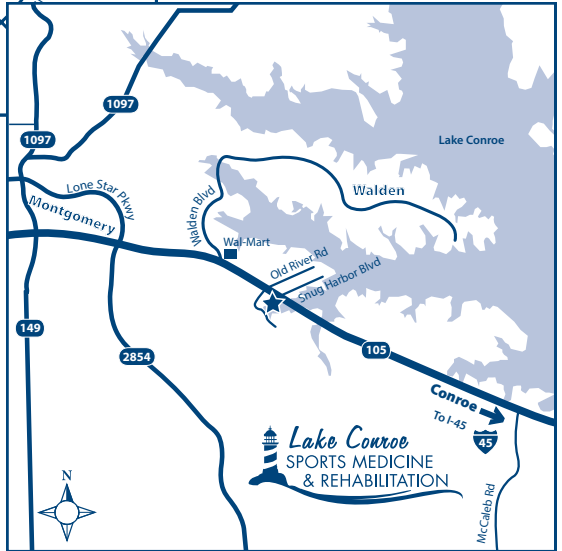
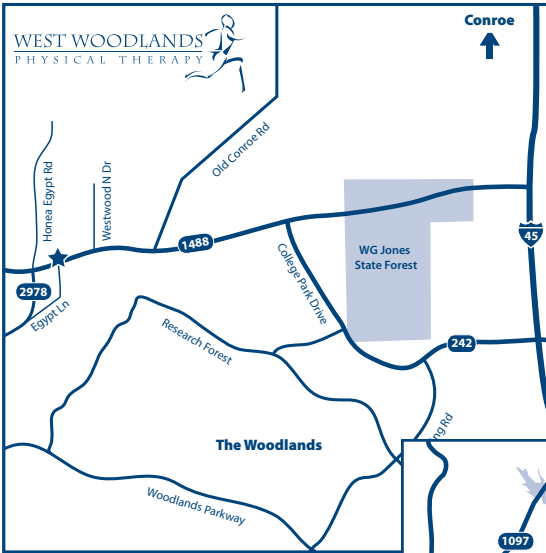
Jason Barranco, MPT
Partner/Clinic Director

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John Fahrner, PT, DPT
Clinic Director

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JUST A REMINDER:

- Please bring this referral slip with you on your first visit.
- Please arrive 15 minutes before your scheduled appointment to complete the necessary paperwork.
- Evaluations (1st visit) usually last 1 to 2 hours.

WHAT TO WEAR:

- Please wear/bring comfortable clothing (e.g. T-shirt, shorts, or sweatpants) and sneakers.