Sport & Spine
PHYSICAL THERAPY

☐ EDGAR
325 South Third Street, Suite B
715.352.2780 fax 715.352.2781

☐ WAUSAU
327 North 17th Ave, Suite 7
715.845.2942 fax 715.842.3416

☐ WITTENBERG
105 N. Genesee Street
715.253.2939 fax 715.253.2930

www.sportspinewi.com

Name: _____ DOB: _____ Date: _____

Diagnosis: _____

Precautions: _____

Worker's Compensation: ☐ Yes ☐ No Adjuster /case manager: _____

Recommended Frequency: _____ Times per week for _____ weeks _____

☐ PHYSICAL/ ATHLETIC/ OCCUPATIONAL EVALUATION AND TREATMENT

ELECTRO-THERAPY
- ☐ Omni-Stim
- ☐ Muscle Stim
- ☐ T.E.N.S.
- ☐ Iontophoresis
- ☐ Biofeedback

SOFT GOODS
- ☐ Bracing
- ☐ Splinting
- ☐ Crutches

COLD/HEAT APPLICATION
- ☐ Hot Packs
- ☐ Cold Packs
- ☐ Ice Massage
- ☐ Ultrasound
  - ☐ With DEX
- ☐ Fluido Therapy

TMD
- ☐ Modalities
- ☐ Posture Training
- ☐ Range of Motion

THERAPEUTIC EXERCISE/ ACTIVITY
- ☐ R.O.M
- ☐ Shoulder Rehabilitation
- ☐ Hand Rehabilitation
- ☐ Knee Rehabilitation
- ☐ Ankle Rehabilitation
- ☐ Back/Neck Rehabilitation
- ☐ Spinal Stabilization
- ☐ Proprioception/Balance Training
- ☐ Functional Activities
- ☐ Fall Risk Assessment

MANUAL THERAPY
- ☐ Mobilization

TRACTION
- ☐ Pelvic
- ☐ Cervical
- ☐ Home Traction Unit

WORK INJURY
- ☐ Functional Testing (Physical Performance Eval)
- ☐ Functional Capacity Evaluation (FCE)
- ☐ Work Hardening/ Conditioning

Other: _____

_____

_____

I hereby certify that the above services have been deemed medically necessary.

Physician Signature: _____ 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.