VINCENT ALARCON PHYSICAL THERAPIST, PC

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OUTPATIENT DEPARTMENT

PRESCRIPTION FORM

Patient Information:

Name:	Age:	Sex: ☐ M ☐ F	Date of Birth:
Address :		Phone #:	Weight:
Diagnosis:	ICD: 10		Height:

Needed Documentation: (in the past 90 days)

- ☐ History & Physical/Progress note
- ☐ Insurance ***ADD*** copy of front & back of card
- ☐ Medlist
- ☐ PT order

List Insurance

- ☐ Lasalle
- ☐ Medicare
- ☐ Anthem Blue Cross
- ☐ Worker's Comp
- ☐ Blue Shield
- ☐ Cash Pay

Please **CALL us to check insurance coverage**

Order:

☐ **PT to Eval and Treat**
Frequency: _____ Duration: _____ Weight bearing: _____

Other Diagnosis

Orthopedic (Specialty)

☐ THA
Precaution
- ☐ Anterior
- ☐ Posterior
- ☐ No hip precaution
- ☐ Progress as tolerated Additional Restriction/Precaution

_____

☐ TKA
- ☐ Progress as tolerated
- ☐ Additional Restriction/Precaution

_____

☐ Ankle and Foot Surgery
- ☐ Progress as tolerated
- ☐ Additional Restriction/Precaution

_____

☐ Other (ORIF) (Fracture)
- ☐ Progress as tolerated
- ☐ Additional Restriction/Precaution

_____

☐ Other
- ☐ _____

Back/Neck/Spinal Surgery

☐ Precautions

☐ Spinal Precaution
- ☐ For how long : _____
  1 No lifting _____ lbs
  2 No bending
  3 No Twisting

☐ Bracing:
- ☐ For how long : _____ on at all times
- ☐ As needed

Physician's Name (Print): NPI #: Date / Time:

Physician's Signature: Phone #: ( ) - Fax #: ( ) -

"Helping Improve Our Patients' Quality of Life"

WE DO NOT TREAT THE BELOW DIAGNOSIS / SCREENING

- *MANDIBULAR JAW DYSFUNCTION*
- *WOMEN'S PELVIC DYSFUNCTION*
- *FUNCTIONAL MOBILITY SCREENING*