Department of Orthopaedic Surgery
Sports Medicine and Shoulder Service

General Physical Therapy Prescription

Patient Name: **Date:**

Diagnosis: ______________________ **Operative / Non-Operative**

Number of visits each week: 1 2 3 4 **Treatment duration_______weeks**

__ Evaluate and treat

Specifics (if not online as noted below):

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__ Prescription protocol is available at *www.slucare.edu/sportsmed*
(located in physical therapy forms link)

Physician Signature: