

Xcelerate Physical Therapy

214 S Newtown Street Rd Newtown Square, PA 19073-4000

Office: 610-624-5111 Fax: 610-624-1324

www.xcelr8pt.com

Patient Name:	Date:	
Diagnosis:		
Precautions:		
Frequency:	_ times per week for	weeks.
EVALUATE & T	REAT	
 ■ Manual Therapy □ Soft Tissue Mobilization □ Joint Mobilization □ Therapeutic Exercise □ Passive ROM □ Active ROM □ Active Assistive ROM □ Progressive Resistive Exercise □ Strengthening □ Stabilization Program □ Core Strengthening □ Closed Chain Exercise □ Posture/Body Mechanics □ Home Exercise Program 	□ Sports Specific Training / R □ Modalities □ As Indicated □ Ultrasound □ Electrical Stimulation □ Iontophoresis □ Phonophoresis □ Traction □ Neuromuscular Re-educati □ Balance / Proprioceptive □ Vestibular Training □ Gait Training	ion
☐ Pre ☐ Post Operative Rehabilitat	ion Protocol for Date of Surgery	
□ Other:		
SPECIAL INSTRUCTIONS:		
The above plan of care is established and volume I certify the medical necessity of therapy.	will be reviewed every 30 days.	
Physician's 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.



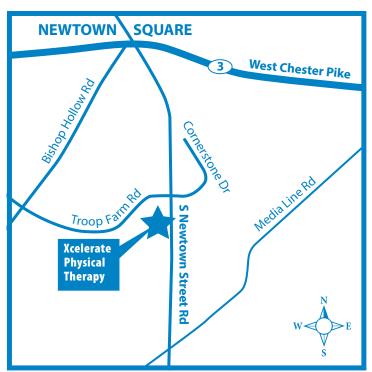
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CONVENIENTLY LOCATED



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.
- The evaluation (1st visit) usually lasts 1 hour.

WHAT TO WEAR:

• Please wear comfortable clothing.