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_____
Referring Provider

VPT
VICTORIA PHYSICAL THERAPY, P.C.

PHYSICAL THERAPY PLAN OF CARE

PT Signature _____

PATIENT _____ DATE OF BIRTH _____ DATE _____

PT DIAGNOSIS _____

_____ SPECIAL PRECAUTIONS: _____

MEDICAL DIAGNOSIS _____

☐ **Evaluate and Treat**
☐ Therapeutic Exercise
☐ Manual Techniques
- Spinal Mobilization
- Joint Mobilization
- Dry Needling
- Myofascial Release
- Manual Traction
- IASTM
- Taping

☐ Home Exercise Program

☐ Gait / Transfer Training
☐ Neuromuscular Re-Education
☐ Mechanical Traction
☐ LSVT – Big
☐ Vestibular Balance Rehabilitation
☐ Health Wellness Education
☐ Weight Loss
☐ Supplies / Modalities / Procedures (PRN)
☐ Other _____
_____
☐ Post Op with Protocol
☐ Post Op w/o Protocol

☐ Therapist Discretion _____ **Provider's Signature** _____

FREQUENCY: _____ **Date:** _____

DURATION: _____ Provider will re-evaluate patient _____