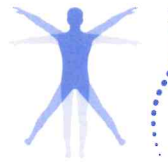


Referring Provider _____



VPT

VICTORIA PHYSICAL THERAPY, P.C.

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VICTORIA ORTIZ-SHEFFEL, PT, DPT
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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: Power Moves

☐ Vestibular Balance Rehabilitation

☐ Health Wellness Education

☐ Annual / PT Exam

☐ Supplies / Modalities / Procedures (PRN)

☐ Other _____

☐ Post Op with Protocol

☐ Therapist Discretion _____ Provider's Signature _____

FREQUENCY: _____ Date: _____

DURATION: _____ Provider will re-evaluate patient _____