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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: 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 _____