



Patient Name: _____ Date: _____

_____ Evaluate and Treat _____ Provide patient with home program

Frequency: _____ x/week x _____ weeks

Modalities:

- _____ Phonophoresis with 0.05% Fluocinonide
- _____ Iontophoresis with 4mg/ml Dexamethasone
- _____ Ultrasound
- _____ Electrical Stimulation

Exercises:

- _____ Back Stabilization Program
- _____ PatelloFemoral Exercise
- _____ Hip Exercise Program

Special Instructions:

ACL Prehab – work on stretching, ROM, Quad/HS activation and strengthening in preparation for ACL reconstruction surgery

By signing this referral, I certify that I have examined this patient and physical therapy is medically necessary. This patient _____ would _____ would not benefit from social services.

Physician Name: _____ Date: _____