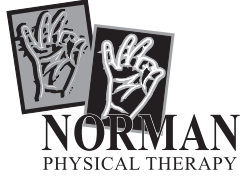


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www.enidtherapy.com

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 1250 North Interstate Drive, 73072
www.normanpt.com

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 916 SW 38th St., Suite C, 73505
www.redbudotandpt.com

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 Physical Therapy
 Tel: 405-745-4786 • Fax: 405-745-4837
 1337 E. State Hwy 152, Suite 111, 73604
www.soonerpt.com

Patient Name: _____ DOB: _____

Diagnosis: _____

Surgical Procedure: _____

Precautions: _____

Frequency: _____ Duration: _____

EVALUATE AND TREAT

THERAPEUTIC EXERCISE

- ROM
- Passive Stretching
- Progressive Strengthening
- Gait Training
- Work Conditioning

MODALITIES

- Paraffin
- Whirlpool
- Iontophoresis
- _____
- Ultrasound/Phonophoresis
- Traction - Cervical/Lumbar

Manual Therapy

Functional Capacity Evals

Hand Therapy

Splinting

Lymphedema

Aquatic Therapy (Enid)

Other _____

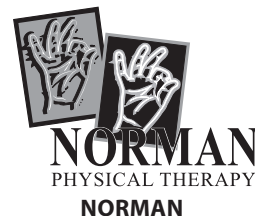
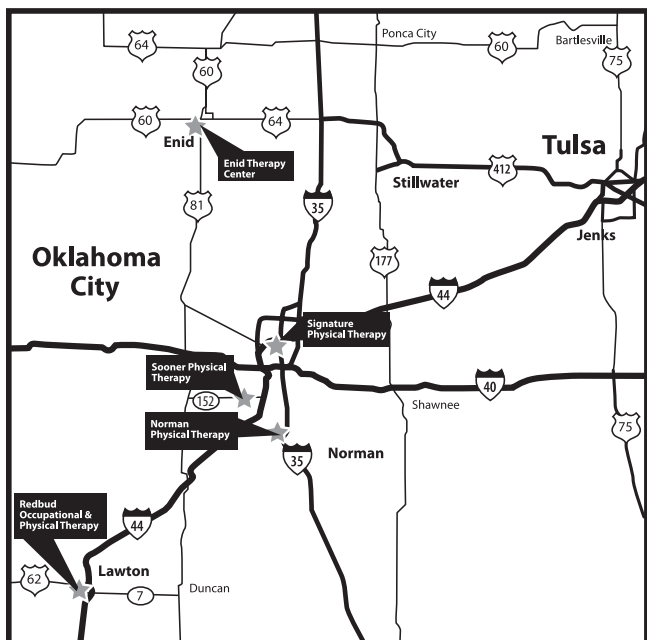
Special Instructions: _____

I hereby certify the above services to be medically necessary.

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.

Please Print Name: _____



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An informational site for patients interested in or considering physical, occupational, and/or hand therapy.