



Brian Waterman, MD

SPORTS MEDICINE & ORTHOPEDICS

PHYSICAL THERAPY / Occupation Therapy PRESCRIPTION R / L Elbow

Name: _____ Date: _____

Diagnosis: _____

Frequency: 1 2 3 4 times / wk Duration: _____ weeks

Range of Motion: Limitations: pain Goals: increase painfree ROM

Method: ___ PROM ___ AAROM ___ AROM ___ Progress as tolerated
Comments:

Strengthening: Limitations: see diagnosis
Goals: increase strength in all planes / Advance as tolerated
Methods: ___ Isometrics ___ Theraband ___ Weights: _____ lbs

Physical Modalities:

Per therapist discretion, please include:

- ___ Electric Stimulation ___ Ultrasound ___ Iontophoresis ___ Phonophoresis
- ___ TENS ___ Heat before/after ___ Ice before/after ___ Trigger points massage
- ___ Therapist's discretion
- ___ Other _____

Comments:

Signature: _____ Date: _____

