RETURN TO SPORT
PHYSICAL THERAPY

Patient Name: ____

Diagnosis: ____

Precautions:
____
____

____ **Evaluate and Treat** ____ **Continue PT**

- Strength
- PROM
- AAROM
- AROM
- Manual Therapy
- Redcord Therapy
- US
- Estim
- Other: ____

Frequency

____ 1-2 X/week ____ 2-3X/week Other ____________

Duration

____ 4 weeks ____ 6 weeks ____ 8 weeks Other ____________

Referring Provider

Print ______________________________ Date ____________

Signature ______________________________

Phone Number ______________________________ Fax ____________

Return to Sport Physical Therapy, SC
293 Northfield Road, Northfield, IL 60093
Phone: (847) 386-6310 Fax: (224) 255-6756
returntosportpt.com