

* Keller/Haslet/Alliance
4120 Heritage Trace Parkway, Ste. 220
Keller, Texas 76244
817-741-7585 FAX 817-741-7587



* North Richland Hills/Hurst
5060 Davis Blvd.
North Richland Hills, Texas 76180
817-498-8585 FAX 817-498-8582

Fossil Creek/Saginaw/Blue Mound
2720 Western Center Blvd., Ste. 312
Fort Worth, Texas 76131
817-847-0200 FAX 817-847-0203

Northwest Keller/Trophy Club/Southlake
816 Keller Pkwy., Ste. 200
Keller, Texas 76248
817-200-7445 FAX 817-431-8665

**Aquatic/Hydroworx® Underwater Physical Therapy Offered at these Locations*

Patient Name _____ Date _____

Patient Telephone Number _____

Diagnosis _____ ICD-9 _____

Precautions or Special Instructions _____

☐ Evaluate and Treat ☐ Continue Therapy Recommended Frequency _____ times per week for _____ weeks.

Sports Medicine Program

- | | |
|--|--|
| <input type="checkbox"/> ACL Protocol | <input type="checkbox"/> Pilates/Spine Stabilization |
| <input type="checkbox"/> Rotator Cuff Protocol | <input type="checkbox"/> Core/Plyometric Training |

Aquatics

- ☐ Aquatics/Hydroworx® Underwater Treadmill

Modalities

- | | |
|---|---|
| <input type="checkbox"/> Ultrasound/Combo | <input type="checkbox"/> Ionto/Phonophoresis |
| <input type="checkbox"/> Traction/Home Traction | <input type="checkbox"/> Soft Tissue/Joint Mobilization |
| <input type="checkbox"/> Neuromuscular Electrical Stimulation | |

I certify that this patient is under my care. The rehabilitation services prescribed by me are medically necessary and in accordance with a plan established and periodically reviewed by me.

Physician Signature _____

Date _____

