



Advanced Recovery Rehab Center
4533 Van Nuys Blvd., Suite 201
Sherman Oaks, CA 91403
818-386-1231
818-386-0483 (fax)
www.advancedrecovery.org

PRESCRIPTION FORM

Patient: _____

Diagnosis: _____

Precautions: _____

_____ **PT evaluation and treatment**

_____ **OT evaluation and treatment**

_____ **ST evaluation and treatment**

_____ **Treatment may include Electrical Stimulation including
Bioness Functional Electrical Stimulation (FES)
H200 for upper extremity and/or L300 for lower extremity**

_____ **Treatment may include Functional Tone Management
(FTM) with SaebFlex Orthosis**

_____ **Constraint-Induced Movement Therapy**

_____ **Constraint-Induced Aphasia Therapy**

_____ **Other:** _____

Frequency & duration: _____ days/wk for _____ wks

****Constraint-Induced Movement or Aphasia Therapy Frequency:
5 days/week up to 6 hours daily x up to 3 weeks**

Physician Signature: _____ **Date:** _____

Physician Name (please print): _____

Ph. No. _____ **Fax No.** _____