



ALTA VISTA
WELLNESS CENTER

Alta Vista Wellness Center

414 Shiloh Dr. Suite 9
Laredo, Texas 78045
(956) 791-8235 Fax: (956) 791-8239

PRESCRIPTION / CLARIFICATION OF ORDERS

PATIENT NAME: _____ **DATE:** _____

DATE OF BIRTH: _____ **AGE:** _____ **SSN#:** _____

DIAGNOSES: _____

REFERRING PHYSICIAN: DR. _____ **PHONE:** _____

REFERRED FOR:

- ☐ PT EVALUATION AND TREATMENT
- ☐ FUNCTIONAL CAPACITY EVALUATION
- ☐ BACK SCHOOL PROGRAM
- ☐ WORK CONDITIONING WITH FCE
- ☐ WELLNESS PROGRAM / CONDITIONING PROGRAM
- ☐ ORTHOPEDIC NUTRITIONAL (OSTOEDENX, JOINT, CALDENX AND LACTOFERRIN)

ADDITIONAL ORDERS: _____

FREQUENCY/DURATION: _____

NEXT MD APPOINTMENT: _____ / _____ / _____

GOALS:

- ☐ DECREASE PAIN
- ☐ INCREASE ROM / STRENGTH
- ☐ IMPROVE GAIT
- ☐ IMPROVE FUNCTIONAL LEVEL
- ☐ INCREASE ENDURANCE
- ☐ OTHERS:

PRECAUTIONS:

- ☐ NON-WEIGHT BEARING
- ☐ PARTIAL WEIGHT BEARING
- ☐ IMBALANCE / INCOORDINATION
- ☐ RISK FOR FALLS
- ☐ CARDIAC PRECAUTION
- ☐ OTHERS:

I CERTIFY MEDICAL NECESSITY FOR THE ABOVE REQUESTED THERAPY,

PHYSICIAN'S SIGNATURE / **DATE**

NPI #