



Prescription for Physical Therapy Services
Kathleen Deyo Stross, PT, MS

Patient: _____ Date: _____

Diagnosis: _____

vertigo _____

gait instability _____

The prescribed evaluation and therapy below is medically necessary for my patient, given the above diagnosis.

Evaluation and treatment in PT _____ x/wk for _____ weeks

Special Instructions: _____

Physician's Signature

Date

Physician's Name (printed)

Physician's Phone Number

Specialist in Vestibular and Balance Rehabilitation for over 20 Years!

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