# PHYSICAL THERAPY PRESCRIPTION

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PATIENT STICKER

**DIAGNOSIS:** **DATE**_____

## ANKLE PHYSICAL THERAPY PRESCRIPTION

___ Ice Massage / Ice Bath / Whirlpool

___ Anti-Inflammatory Modalities

___ Range of Motion Active / Active-Assisted / Passive

___ Flexibility

___ Compression – Aircast / Jobst Intermittent Compression

___ Isometrics for Inversion / Eversion – Progress to Isokinetics and Isotonics

___ Isotonics for Plantar / Dorsiflexion

___ Proprioception training, BAPS

___ Advance to Lateral step-ups, Sport-cord, Euroglide

**Treatment: _____ times per week** **___ Home Program**

**Duration: _____ weeks**

**Please send progress notes.

**Physician's Signature:_____**
**Frank Petrigliano, MD, Attending Orthopaedic Surgeon, UCLA**