Sullivan Physical Therapy
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Prescription for Physical Therapy
Women's & Men's Health

Patient: _____ Date: _____

Date of Birth: _____ Phone Number: _____

Diagnoses we treat include, but are not limited to, the following:

Abdominal Pain
Anal/Rectal Pain
Cystocele
Coccygodynia
Constipation
Damage to Pelvic Joints and Ligaments
Detrusor Sphyincter Dyssynergia
Diastasis Recti
Dyspareunia
Dysmenorrhea
Dysuria
Endometriosis
Fecal Incontinence
Fecal Urgency
Flatulence
Incomplete Bladder Emptying
Interstitial Cystitis
Irritable Bowel Syndrome
Low Back Pain
Mixed Incontinence
Muscle and Tissue Atrophy
Myalgia
Overactive Bladder Syndrome
Pelvic/Genital Pain, Female
Pelvic/Genital Pain, Male
Post Void Dribbling
Prostatitis, Chronic
Prostatodynia
Pudendal Neuralgia
Rectocele
Sacral Iliac Joint Dysfunction
Sciatica
Spasm, Anus/Ani Sphincter
Spasm of Muscle
Sprain/Strain of Pelvis
Stress Incontinence
Urge Incontinence
Urinary Frequency
Urinary Urgency
Uterine Prolapse
Vaginismus
Vestibulodynia
Vulvodynia

Diagnosis: _____

ICD10: _____

Specific Recommendations: _____

_____

In my opinion, in accordance with accepted medical practice standards, the above mentioned patient requires rehabilitation services for their impairments and functional limitations. I hereby request that a Physical Therapist evaluate and treat the patient's needs for such services and provide me with a detailed plan of care for my approval.

Provider's Printed Name:_____
(MD, DO, PA, NP, CNM, DC)

Provider's Signature: _____