JAGLOWSKI
ORTHOPEDIC
INSTITUTE

**Patient Name**: _____

**DOB**: _____

# Rx Physical Therapy

**Diagnosis**: _____

**Surgery**: _____

- Please eval and treat per our protocol (attached).
- Modalities as indicated.
- Please instruct with home program.
- Instructions at www.jagsortho.com.

***Frequency***: 2-3 times per week
***Duration***: 2 months

Refill _____ times

Date _____

**Jeffrey R. Jaglowski MD, MBA, MSc**