

# Guide to Therapy Prescription Writing

*Gautam Malhotra, James F. Wyss, and Amrish D. Patel*

## INTRODUCTION: A FAREWELL TO “PLEASE EVALUATE AND TREAT”

When “please evaluate and treat” is the entire prescription, it puts the entire responsibility of developing a treatment plan on the therapist. Although some therapists have grown to enjoy the autonomy that this type of practice has engendered, in the end, this situation results in the patient losing the benefits of an interdisciplinary approach to care. In the authors’ experiences the answer is quite clear: If you were to ask any patient whether they would prefer to be treated by multiple separate clinicians (multidisciplinary approach) or a team of clinicians who work together on developing a diagnosis and treatment plan (interdisciplinary approach), they would prefer the interdisciplinary team approach.

Like many residents and fellows, the authors quickly realized that they would never be equally proficient to a therapist at delivering hands-on modalities, functional training, or exercise education. Also, the therapist tends to spend hours with the patient while their interactions with patients are much shorter and less frequent encounters. As the prescribing clinicians, this was a humbling realization and has resulted in the practice of genuinely seeking and honoring the feedback, advice, evaluations, and outcomes delivered by therapists. This in turn builds respect and lines of communication from the therapist back to the prescribing physician. In the end, the patient reaps a more comprehensive yet expeditious experience derived from such an interdisciplinary team approach.

If you are reading this book, it means you are a clinician who is interested in taking an active role in the rehabilitation of your patients. Whether you are a physiatrist, family physician, sports medicine specialist, rheumatologist, internist, or surgeon, this book is an attempt to bridge some of the gaps between the prescribing physician and the therapist. It is *not* meant to be a cookbook with recipes for a dogmatic cookie-cutter approach to prescriptions. Templates can be useful starting points to ensure all

options are considered and to streamline the delivery of a prescription. However, in their experience, therapists do not respond as well to long lists that are not individualized to the patient’s particular situation. Patients do not recover or rehabilitate productively with this approach either.

## APPROACH TO THERAPY PRESCRIPTION WRITING

In addition to the thoughts above, here are some specific thoughts to consider as you work to individualize your prescriptions:

- You will prescribe therapy much like you would a medication. You have to know the patient, the problem that you are addressing, concurrent problems that could affect your prescription, and most important, what the goal is
- Use therapy like it’s your bag of tricks to accomplish treatment goals. The prescription requires a thoughtful goal-oriented approach rather than a mindless cookbook recipe approach. (Do *not* just copy and paste)
- It is helpful to think about the following questions:
  - What therapeutic modalities are safe and beneficial for my patient?*
  - What types of manual therapy techniques would be beneficial?*
  - What structures are weak and need to be strengthened? What structures are tight and need to be stretched or lengthened?*
  - What movements are poorly coordinated or have biomechanical faults that need to be retrained and corrected?*
  - What other impairments (e.g., poor balance, impaired proprioception) exist?*

*What activities or positions should be avoided due to their detrimental effects versus what activities or positions should be encouraged to promote recovery? What educational training and resources would be helpful for my patient?*

- Some components of the prescription may require detailed specificity to ensure that the therapist understands it to be important in your thought process. Flexibility in other components of the prescription will be appreciated by your therapist as it will allow some personalization at the time of therapy. So be careful to consider every word in your prescriptions in order to avoid over-writing as well. The balance of writing enough but not too much is more like an art that takes years of experience with the therapists and patient populations in your community

## COMPONENTS OF A THERAPY PRESCRIPTION

The prescription may incorporate the following fields (see sample Rx at the end of the chapter).

### Identifying Information

Including the patient's name, date of birth, medical record numbers etc... along with the date the prescription was written.

### Discipline

Indicate physical therapy (PT) or occupational therapy (OT). Although these are the main disciplines considered in this textbook other disciplines may need to be included as well: athletic training, exercise physiology, massage therapy, recreational therapy, even speech and language pathology.

### Diagnosis

Begin with your primary diagnosis, then secondary diagnoses if relevant. Identify contributing factors to the diagnosis (e.g., tight hamstrings in the setting of mechanical low back pain). Also identify relevant past medical and surgical history to effectively communicate with the therapist.

### Problem List (Optional)

This section provides an additional way to communicate mechanical and functional deficits that may be contributing factors to the development of the diagnosis or that may lead to delayed rehabilitation of the condition if not properly addressed. An example would include decreased passive and active ankle dorsiflexion following acute lateral ankle sprain. Failure to restore this range of motion (ROM) may lead to incomplete functional recovery or recurrent ankle sprains.

### Precautions

Spend time detailing precautions for the patient's therapy program; examples include weight bearing restrictions, ROM restrictions, and specific exercises to avoid. Precautions will be dictated by information elicited on history and physical examination. Does the patient have a history of falls or are they at significant risk of future falls? Cardiac or pulmonary disease? Seizures? Is there a history of severe osteoporosis necessitating fracture risk precautions? Are they insensate in areas that may burn if heat is used or develop pressure ulcers if unchecked? Do they have any breaks or openings in the skin? Are there issues that need to be resolved/clarified/cleared by other physicians (e.g., surgeon, cardiologist, internist) before therapy can be initiated?

### Frequency of Visits

Most prescriptions are written "2-3x/week," but please take the time to consider the needs of the specific patient. An athletic patient with good body awareness may adequately progress with weekly visits and a daily home exercise program. Whereas patients with acute injuries or postsurgical cases may initially require more frequent visits. The burdens of being a sole caregiver, sole provider, or difficulty with travel or financial limitations may play a part in the decision on frequency of treatment. Every effort must be made to consider these practical impediments to participation.

### Duration of Treatment

The most common length of treatment is 4 to 6 weeks, but take the time to individualize the duration as well. Based on known natural history or acuity of the condition, shorter (1-2 weeks) or longer (> 6 weeks) may be anticipated for improvement or resolution.

## Treatment

This part of the Rx is the most challenging and may be overwhelming the first time you do it. It is useful to approach it systematically with the list in the text box and by applying the concepts or questions discussed in the “*approach to therapy prescription writing*” section.

## Therapeutic Modalities

- **Thermotherapy:**
  - Cryotherapy: (ice pack, ice bath, ice massage) for inflammation/swelling/pain
  - Superficial heat therapy: (hot packs, warm bath, paraffin, fluidotherapy, whirlpool, contrast baths) for pain relief and to enhance recovery
  - Deep heat therapy: ultrasound, short wave diathermy, laser therapy
- **Phototherapy:** laser therapy, UV light
- **Electrical stimulation:** transcutaneous electrical nerve stimulation (TENS), interferential current (IFC), functional electrical stimulation (FES), neuromuscular stimulation (NMES), Iontophoresis

## Manual Therapy

- Massage, joint mobilization, myofascial release (MFR), soft-tissue mobilization, acupressure, transverse friction massage, positional release or counter-strain, traction (manual, mechanical) are some techniques to consider for your patient

## Therapeutic Exercise

- ROM exercises: passive, active assisted, active
- Stretching: self-stretching, therapist-assisted stretching, contract-relax stretching
- Strengthening: generalized strengthening or identify the need to strengthen specific muscle groups, isotonic (eccentric/concentric) versus isometric, closed versus open kinetic chain progressive resistive exercise (PRE), core strengthening or stabilization programs
- Balance/proprioceptive training, neuromuscular reeducation
- Conditioning exercises: this may be indicated as general conditioning exercises (GCEs) or if necessary, specific programs with a warm-up/cool down, duration and type of exercise may be considered. Examples include:

Upper body ergometry (UBE), treadmill, upright or recumbent stationary bike, or ambulation training with or without assistive devices (e.g., parallel bars)

## Specialized Treatments

- Some examples include the use of aquatic therapy or kinesiology taping
- Other examples include analysis of the kinetic chain, functional movement screen, or even a running analysis could be considered here
- The prescribing physician may also request a specific therapeutic approach in this section, such as mechanical diagnosis and therapy (MDT), also known as the McKenzie method
- Other examples are related to task specific functions, such as:
  - **Mobility training:** kinetic chain or biomechanical analysis and training, gait analysis and training, transfer training, postural analysis and training
  - **Activities of Daily Living (ADL) training:** Personal care activities with or without adaptive equipment such as dressing, eating, or personal hygiene
  - **Instrumental ADL:** These activities are related to independent living but not necessary for fundamental functioning (e.g., food preparation, accounting, housework, etc.)
  - **Equipment:** Use of specific supportive or assistive devices, orthotic training, and durable medical equipment to aid in all of the above categories

## Patient Education

Patient education is provided to the patient and possibly their family in the form of verbal, visual, and written instruction; or digital media. Examples of patient education include an explanation of their specific condition and associated prognosis, home exercise program, and postural education. Joint protection and energy conservation techniques are other examples. In addition, all of the therapeutic exercises discussed above have an educational component and require carryover by the patient to change posture, correct movement patterns, and eliminate causative factors of pain.

## Reevaluation

Time until physician reevaluation should be clearly communicated with the patient and the therapist. Communicating

with the providing therapist is crucial. Therapists vary in their training, experience, skill sets, biases, philosophies on healthcare delivery, and even bedside manner, just as physicians do. We recommend getting to know the therapists at your hospital and in your local community. Knowing their strengths and weaknesses in these fields will be a crucial step in correctly pairing patients and therapists to successfully obtain favorable outcomes. In addition, you will need to communicate (written or verbally) with the therapist to make sure they are following the therapeutic program you have prescribed and what the outcomes have been, just as you would with a nurse regarding a prescribed medication.

We recommend requesting formal feedback on patient progress to help guide your reevaluation. Read the therapist's notes or call them to clarify the patient's progress and tolerance to the therapeutic program. Their feedback is vital when reassessing the patient's condition, when deciding to continue or discontinue your patient's therapy program, and when deciding if additional diagnostic studies or treatments are necessary. If therapy is to be continued, the prescription should change at follow-up to incorporate the progress and/or changes in symptomatology.

#### SUMMARY

Therapy prescription writing is more of an art than a science. If you invest time and effort into this part of your practice we do believe it will influence patient outcomes. In this chapter, we have presented a "guide to therapy prescription writing" that can be utilized for the overall framework, concepts, and systematic approach. As you become more comfortable with your practice and develop relationships with therapists at your hospital and in your community, your style of writing will evolve, but always remember to utilize it to establish a team approach to care that provides all the necessary medical information to the treating therapist and treatment recommendations that are evidence based and individualized to your patient.



#### SAMPLE THERAPY PRESCRIPTION

**Name with identifying factors:** (e.g., DOB)

**Date:**

**Discipline:** PT, OT, or other

**Diagnosis or diagnoses:**

**Problem list:**

**Precautions:**

**Frequency of visits:** such as 2 to 3x/week.

**Duration of treatment:** such as 3 to 4 weeks; or 8 to 12 total visits used at the therapist's discretion

**Treatment:**

1. **Therapeutic modalities:** such as heat or cold packs, electrical stimulation
2. **Manual therapy:** such as MFR, massage, or joint mobilization
3. **Therapeutic exercise:** such as active, active assisted, and passive range of motion (A/AA/PROM), stretching, strengthening/PREs, balance/proprioceptive training, neuromuscular reeducation, or conditioning exercises
4. **Specialized treatments:** kinesiology taping, aquatic therapy, or kinetic chain analysis
5. **Patient education:** such as written home exercise program

**Goals:** such as decrease pain and swelling, restore ROM/flexibility then strength, or safely return to functional activities (e.g., sport, hobbies, and work)

**Reevaluation:** such as 3 to 4 weeks by referring physician.