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# Physical Therapy Prescription
# Greater Trochanteric Bursitis

**Patient Name:** **Today's Date:**

**Dx: (LEFT / RIGHT) GT Bursitis**

**Modalities:**

___ Evaluate & Treat
___ Assess for Flexibility, Strength
___ WBAT, Gait training
___ Range of Motion - Painfree AROM / AAROM / PROM
___ Progressive strengthening –
Hamstrings / Hip Adductors / Hip Abductors / Hip Flexors
Gluteals / Gastroc-Soleus
___ ITB stretching / strengthening
___ Balance training, Proprioception
___ Core control / Pelvic stability beginning in neutral, progress to multi-planar movements
___ Modalities prn (ultrasound, e-stim)

**Frequency & Duration:** (circle one) 1-2 2-3 x/week for _____ weeks Home Program

**Please send progress notes.

**Physician's Signature:_____ M.D.**