

PATIENT'S NAME: \_\_\_\_\_ DOB \_\_\_\_\_ PHONE: \_\_\_\_\_

DIAGNOSIS / ICD CODE: \_\_\_\_\_

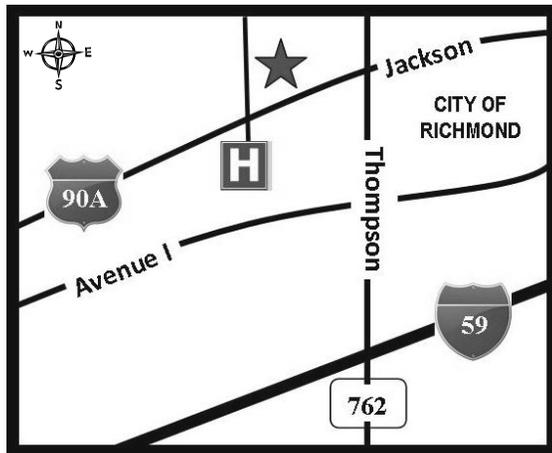
PRECAUTIONS: \_\_\_\_\_

PHYSICAL THERAPY		SPECIALTY PROGRAMS	
<input type="checkbox"/> <b>EVALUATE &amp; TREAT</b>	<input type="checkbox"/> MODALITIES (Elect Stim, Ultrasound, Iontophoresis, Infrared)	<input type="checkbox"/> <b>POST-SURGICAL CARE</b> (please supply Op report & protocol)	<input type="checkbox"/> OSTEOPOROSIS PROGRAM
<input type="checkbox"/> THERAPEUTIC EXERCISE (Active, Passive, PRE)	<input type="checkbox"/> FLUIDOTHERAPY	<input type="checkbox"/> ACTIVITY PRESCRIPTION PROGRAM - General Exercise for Health / Disease Prevention - Oncology / Cancer Conditioning - Diabetes Management through Activity	<input type="checkbox"/> POST-MASTECTOMY CARE
<input type="checkbox"/> FUNCTIONAL ACTIVITIES (Gait, Balance, ADL)	<input type="checkbox"/> THERMAL MODALITIES (Ice, Moist Heat)	<input type="checkbox"/> ARTHRITIS PROGRAM	<input type="checkbox"/> POSTURE / STABILITY
<input type="checkbox"/> NEUROMUSCULAR RE-EDUCATION	<input type="checkbox"/> TRACTION (Lumbar, Cervical)	<input type="checkbox"/> BALANCE / FALL PREVENTION / VESTIBULAR REHABILITATION	<input type="checkbox"/> TMJ / CRANIOFASCIAL / HEADACHES
<input type="checkbox"/> MANUAL THERAPY (Joint & Soft Tissue Mobilization)	<input type="checkbox"/> COMMENTS: _____ _____ _____	<input type="checkbox"/> CARDIOPULMONARY PHYSICAL THERAPY	<input type="checkbox"/> WORK INJURY / RETURN TO WORK / WORK CONDITIONING
<input type="checkbox"/> AQUATIC THERAPY		<input type="checkbox"/> NEURO / STROKE RECOVERY PROGRAM	<input type="checkbox"/> FCE
		<input type="checkbox"/> WOMEN'S HEALTH / PELVIC FLOOR THERAPY	<input type="checkbox"/> ASSESSMENT & FITTINGS (wheelchairs, braces & orthotics)
			<input type="checkbox"/> SUPPLIES FOR HOME USE: _____ _____
			<input type="checkbox"/> OTHER: _____ _____

Comments / Parameters: \_\_\_\_\_ Frequency: \_\_\_\_\_ times per week for \_\_\_\_\_ weeks.

Physician Signature: \_\_\_\_\_ Authorization #: \_\_\_\_\_

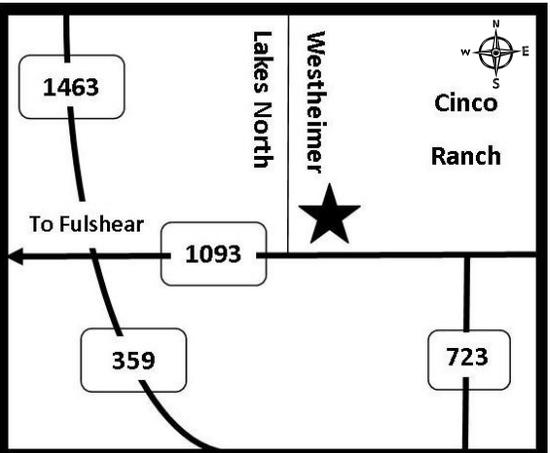
Print Physician's Name: \_\_\_\_\_ NPI#: \_\_\_\_\_ Phone: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_



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