PATIENT'S NAME: ______________________ DOB ______________ PHONE: ______________

DIAGNOSIS / ICD CODE: ____

PRECAUTIONS: ____

PHYSICAL THERAPY

- ☐ **EVALUATE & TREAT**
- ☐ THERAPEUTIC EXERCISE (Active, Passive, PRE)
- ☐ FUNCTIONAL ACTIVITIES (Gait, Balance, ADL)
- ☐ NEUROMUSCUSLAR RE-EDUCATION
- ☐ MANUAL THERAPY (Joint & Soft Tissue Mobilization)
- ☐ AQUATIC THERAPY
- ☐ MODALITIES (Elect Stim, Ultrasound, Iontophoresis, Infrared)
- ☐ FLUIDOTHERAPY
- ☐ THERMAL MODALITIES (Ice, Moist Heat)
- ☐ TRACTION (Lumbar, Cervical)
- ☐ COMMENTS:

____
____
____

SPECIALTY PROGRAMS

- ☐ **POST-SURGICAL CARE (please supply Op report & protocol)**
- ☐ ACTIVITY PRESCRIPTION PROGRAM
  - General Exercise for Health / Disease Prevention
  - Oncology / Cancer Conditioning
  - Diabetes Management through Activity
- ☐ ARTHRITIS PROGRAM
- ☐ BALANCE / FALL PREVENTION / VESTIBULAR REHABILITATION
- ☐ CARDIOPULMONARY PHYSICAL THERAPY
- ☐ NEURO / STROKE RECOVERY PROGRAM
- ☐ OSTEOPOROSIS PROGRAM
- ☐ POST-MASTECTOMY CARE
- ☐ POSTURE / STABILITY
- ☐ TMJ / CRANIOFASCIAL / HEADACHES
- ☐ WORK INJURY / RETURN TO WORK / WORK CONDITIONING
- ☐ FCE
- ☐ ASSESSMENT & FITTINGS (wheelchairs, braces & orthotics)
- ☐ SUPPLIES FOR HOME USE:

____
____

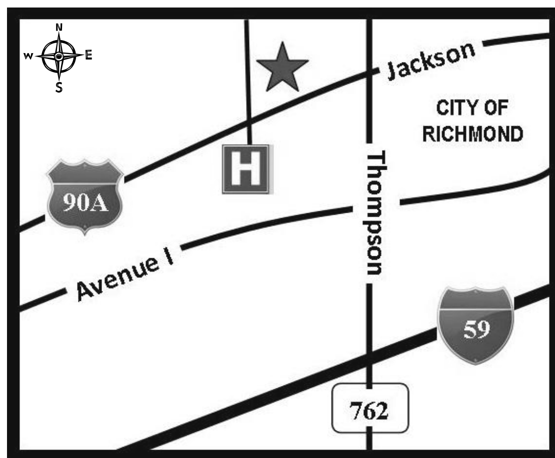
- ☐ OTHER:

____
____

Comments / Parameters: ______________________ Frequency: ______ times per week for ______ weeks.

Physician Signature: ______________________ Authorization #: ______________

Print Physician's Name: ______________________ Date: ______________



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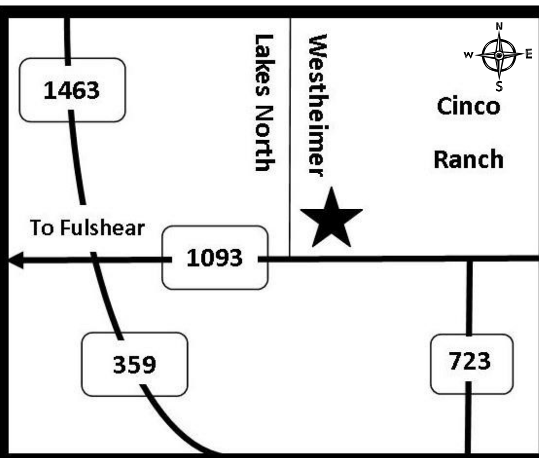

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