



Patient Name	DOB
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Diagnosis	ICD-9 Code
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Precaution/Restrictions

Radiographic Results

Physical Therapy

- Evaluate and Treat
- Gait and Balance Training
- Crutch Training (WB _____)
- Assistive Device/Bracing
 - Crutches
 - Walker
 - Cane
 - Other _____
- Strengthening/Stretching
- Prosthetic Training
- Lumbar Stabilization
- Manual Therapy
- Myofascial Release
- Home Exercise Program

Vestibular Therapy

- Evaluate and Treat

Occupational Therapy

- Evaluate and Treat
- Upper Extremity:
 - Elbow
 - Wrist
 - Hand
- ROM:
 - Passive _____
 - Active Assistive _____
 - Active _____
- Strengthening _____
- Splinting (Please specify):

- Home Exercise Program
- ADLs (self-care, home/work tasks)
 - Assistive Device/DME
- Cognitive/Perceptual Training
- Work Capacity Evaluation
- Work Conditioning
- Ergonomic/Body Mechanics
- Functional Capacity Evaluation

Lymphedema

- Evaluate and Treat PT/OT
- Garment Fitting
- Risk Reduction

Speech & Language

- Evaluate and Treat
- Dysphagia Evaluation
- Video Fluoroscopic Swallow Study (VRSS) with Speech Pathologist
- Voice/Fluency Evaluation
- Augmentative Communication Evaluation
- Other: _____

Modalities

- | | | | |
|--|--|--------------------------------------|---|
| <input type="checkbox"/> Ultrasound | <input type="checkbox"/> Fluidotherapy | <input type="checkbox"/> Heat/Ice | <input type="checkbox"/> Iontophoresis with |
| <input type="checkbox"/> E-Stimulation | <input type="checkbox"/> Frequency Specific Microcurrent | <input type="checkbox"/> Paraffin | <input type="checkbox"/> Dexamethasone |
| | <input type="checkbox"/> Traction | <input type="checkbox"/> Other _____ | |

Other: _____

Frequency: _____ X/week for _____ weeks

Comments

Physician Name (print)	Telephone Number
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Physician Signature	Date
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Physician License Number