NORTH PLATTE PHYSICAL THERAPY

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REQUISITION / PLAN OF CARE

Patient's Name: _____ Phone #: _____

Address: _____

Date of Birth: _____ Referring Physician: _____

Diagnosis: _____

Is patient/guardian aware of diagnosis? _____ Yes _____ No

Onset: _____

Treatment Goals: _____

Treatment Precautions: _____

Treatment Orders: (Please Check)

_____EVALUATION
- _____Consult
- _____Evaluate and Treat
- _____(Area) _____
- _____Re-evaluate

_____EDUCATION
- _____Back School
- _____Cardiac Rehab

_____PRE-OP TEACHING

_____HOME PROGRAM

_____CRYOTHERAPY
- _____Cold Packs
- _____Ice Massage

_____HEAT (Specify Area)
(Superficial)
- _____Hot Packs
- _____Paraffin
- _____Ultrasound

_____IONTOPHORESIS

_____PHONOPHORESIS

_____ELECTRICAL STIMULATION
- _____TENS
- _____HVGS: IFC, Pre Mod
- _____FES
- _____Home Unit

_____EXERCISE (Specify Area)
_____
- _____Strengthening
- _____PROM (Passive ROM)
- _____AROM (Active ROM)
- _____PRE (Progressive Resistive Exercises)
- _____Muscle Reeducation
- _____Coordination
- _____Conditioning Program
- _____Myofacial Release

_____TRACTION
- _____Cervical
- _____Lumbar
- _____Home Unit

_____GAIT TRAINING
- _____Crutch Ambulation
- _____Transfer Instruction
- _____Progressive Ambulation
(Specify WT-Bearing Status)
  - _____NWB R L
  - _____PWB R L
  - _____W.B. as tol. R L
  - _____Touch-down R L

_____POOL THERAPY

_____VISUAL PROCESSING

_____COGNITIVE RE-TRAINING

_____MANUAL THERAPY
(Specify Area)
- _____PROM/Stretching
- _____Joint Mobilization
- _____Massage/STM
- _____Manual Traction

_____TDN (Trigger Point Dry Needling)

_____GRASTON

_____CUPPING

_____WOUND CARE
- _____Wound Whirlpool
- _____Debridement
- _____Dressings
- _____(Other) _____

_____SPLINTING, BRACING
or Orthotics

_____SENSORY PROCESSING

_____PELVIC FLOOR

_____WOMENS HEALTH

_____OTHER
_____
_____

_____Goals and Objectives
have been met

_____Patient Care has been discontinued
_____

Frequency of Treatment: _____ Duration: _____

Date: _____ 20 _____ x _____
Physician's Signature