BIG COUNTRY REHABILITATION, LLC

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PHYSICAL/OCCUPATIONAL THERAPY REQUISITION
PLAN OF CARE

Patient's Name _____ Date of Birth_____

Address _____

Referring Physician _____

Diagnosis_____

Onset Date _____ Pt. aware of Dx _____ Yes _____No

TREATMENT DESIRED

____ Advanced Rehab
____ Braces and Supportive Garments
____ Cardiac Rehab
Electric Stimulation
____ TENS
____ EMS
____ HVGS
____ Acuscope
____ Evaluation
____ Gait Training
____ Cane
____ Crutches
____ Walker
____ Weight Bearing Status
Full Partial None
____ Hot Packs / Cold Packs
____ Home Program
____ Iontophoresis
____ Massage
____ Goals and objectives
Have been met
____ Adaptive Driving

____ Patient care has been discontinued
____ Mobilization
____ Orthotics
____ Paraffin Bath
____ Phonophoresis
____ Pool Therapy
____ Therapeutic Exercise
____ AROM
____ Strengthening
____ Stretching
____ PROM
____ PRE (Resistive)
____ Functional Activities
____ Traction
____ Cervical
____ Lumbar
____ Manual
____ Mechanical
____ Ultrasound
____ Whirlpool

____ Sterile
____ Dressing
____ debridement

Other_____

Frequency _____ Duration _____

Goals _____

Precautions _____

Date _____ Signature X _____