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
- ____ 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 _____