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Patient's Name: ____________________

Address: ____________________ Phone Number: ____________________

Date of Birth: ____________________ Referring Physician: ____________________

Diagnosis: ____________________

Is Pt. aware of diagnosis? _________ Yes _________ No Dx Codes: ____________________

____

Onset: ____________________ Treatment Precautions: ____________________

Treatment Goals: ____________________

Treatment Orders: (Please Check)

_____ **EVALUATION**
- _____ Consult
- _____ Evaluate and Treat (Area) ____________
- _____ Re-evaluate

_____ **CRYOTHERAPY**
- _____ Cold Packs
- _____ Ice Massage

_____ **ELECTRICAL STIMULATION**
- _____ TENS
- _____ HVGS: IFC, Pre Mod
- _____ FES
- _____ Home Unit

_____ **EXERCISE** (Specify Area)

____
- _____ Strengthening
- _____ PROM (Passive ROM)
- _____ AROM (Active ROM)
- _____ AAROM (Active Assistive Range of Motion)
- _____ PRE (Progressive Resistive Exercises)
- _____ Muscle Reeducation
- _____ Stretching
- _____ Coordination
- _____ Conditioning Program

_____ **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

_____ **HEAT** (Specify Area) (Superficial)
- _____ Hot Packs
- _____ Paraffin
- _____ Ultrasound
- _____ Immersion Ultrasound
- _____ Whirlpool
- _____ Contrast Baths

_____ **MANUAL THERAPY** (Specify Area)
- _____ PROM/Stretching
- _____ Joint Mobilization
- _____ Massage/STM
- _____ Manual Traction
- _____ Graston Technique
- _____ SASTYM
- _____ TPDN

_____ **PHONOPHORESIS / IONTOPHORESIS**

_____ **PRE-OP TEACHING**

_____ **SPLINTING, BRACING** or Orthotics

_____ **TRACTION**
- _____ Cervical
- _____ Lumbar
- _____ Home Unit
- Lbs. ____________

_____ **WOUND CARE**
- _____ Wound Whirlpool
- _____ Debridement
- _____ Dressings
- _____ (Other) ____________

_____ **INTERMITTENT COMPRESS** (Specify Area)

____
- mm. of Hg ____________
- _____ Compression Garment

_____ **HOME PROGRAM**

_____ **OTHER**

____

____

____

Frequency of Treatment: ____________________ Duration: ____________________

Date ____________________ 20 _________ **X** ____________________

Physician's Signature