NORTH PLATTE PHYSICAL THERAPY

TODD GENTZLER, PT, OCS
MELISSA METCALF, PT
BENJAMIN COOKSEY, DPT, CSCS

620 4J Court Ste B
Gillette, Wyoming 82716
(307) 686-2569
Fax (307) 686-2615

DEB PERCIFIELD, PTA
KACEE PIKULA, PTA
JULIE TERHUNE, PTA,CSCS,CKTP
NICOLE ACKERMANN, LAT

REQUISITION / PLAN OF CARE

Patient's Name: _____

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

_____ MANUAL THERAPY (Specify Area)
- _____ PROM/Stretching
- _____ Joint Mobilization
- _____ Massage/STM
- _____ Manual Traction

_____ TDN (Trigger Point Dry Needling)

_____ GRASTON

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

_____ SPLINTING, BRACING or Orthotics

_____ SENSORY PROCESSING

_____ COGNITIVE RE-TRAINING

_____ VISUAL PROCESSING

_____ OTHER
_____
_____

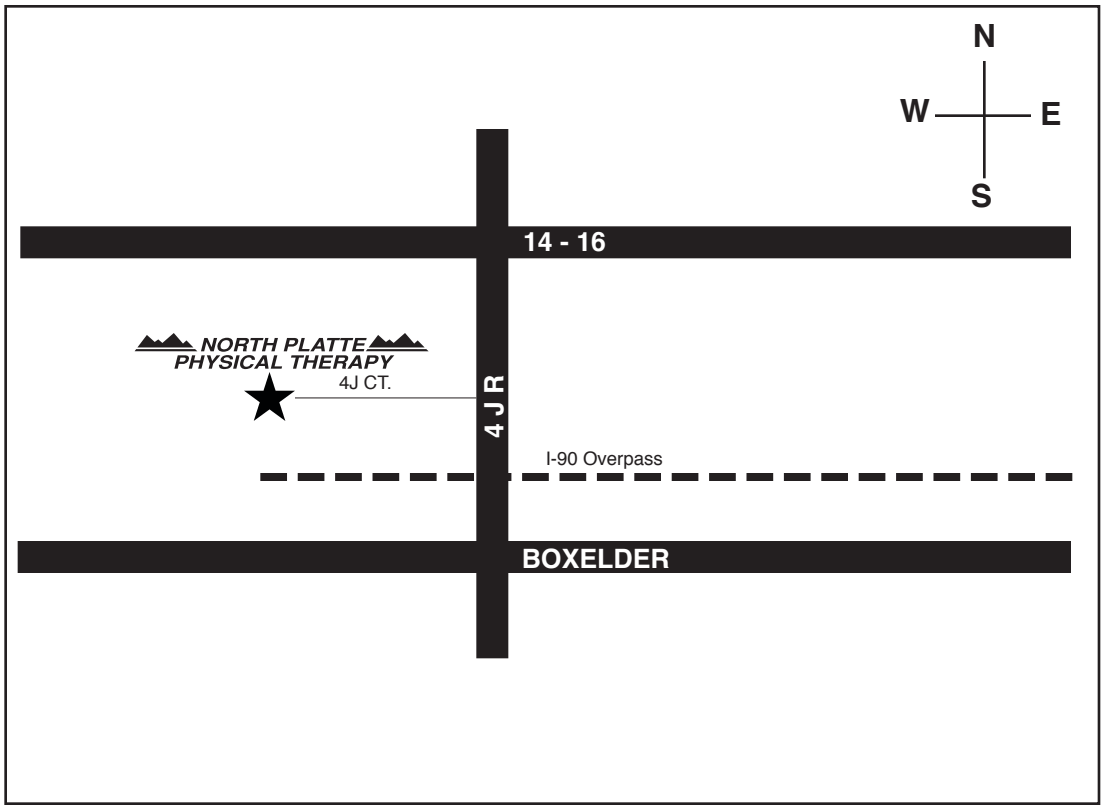
_____ Goals and Objectives have been met

_____ Patient Care has been discontinued
_____

Frequency of Treatment: _____ Duration _____

Date_____ 20_____ **X** _____

Physician's Signature


N
W
E
S
14 - 16
NORTH PLATTE
PHYSICAL THERAPY
4J CT.
4 J R
I-90 Overpass
BOXELDER