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REQUISITION / PLAN OF CARE

Patient's Name: ____________________

Address: ____________________

Date of Birth: ____________________ Referring Physician: ____________________

Diagnosis: ____________________

Is Pt. aware of diagnosis? _____ Yes _____ No

Onset: ____________________

Treatment Goals: ____________________

Treatment Precautions: ____________________

Treatment Orders: (Please Check)

_____ CRYOTHERAPY
- _____ Cold Packs
- _____ Ice Massage

_____ EDUCATION
- _____ Back School
- _____ Cardiac Rehab

_____ ELECTRICAL STIMULATION
- _____ TENS
- _____ HVGS
- _____ FES
- _____ LVS (Acuscope)
- _____ Interferreritial

_____ EVALUATION
- _____ Consult
- _____ Evaluate and Treat
- (Area) __________

_____ EXERCISE (Specify Area)

____
- _____ Strengthening
- _____ PROM (Passive ROM)
- _____ AROM (Active ROM)
- _____ PRE (Progressive) Resistive Exercises
- _____ Muscle Reeducation
- _____ Stretching
- _____ Coordination
- _____ Conditioning Program
- _____ Myofacial Release

_____ GAIT TRAINING
- _____ Crutch Ambulation
- _____ Progressive Ambulation (Specify WT-Bearing Status)
- _____ NWB R L
- _____ PWB R L
- _____ W.B. as tol. R L
- _____ Touch-down W R L
- _____ Transfer Instruction

_____ HEAT (Specify Area)

(Superficial)
- _____ Hot Packs
- _____ Paraffin
- _____ Ultrasound

(Hydrotherapy)
- _____ Whirlpool
- _____ Contrast Baths

_____ HOME PROGRAM

_____ INTERMITTENT COMPRESS (Specify Area)

____

mm. of Hg __________
- _____ Compression Garment

_____ IONTOPHORESIS

_____ MASSAGE (Specify Area)

____

_____ PHONOPHORESIS

_____ POOL THERAPY

_____ PRE-OP TEACHING

_____ SPLINTING OR BRACING

_____ STRESS MANAGEMENT PROGRAM

_____ TRACTION
- _____ Cervical
- _____ Lumbar
- _____ Home Unit
- Lbs. __________

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

_____ OTHER

____

____

____

_____ Goals and Objectives have been met

_____ Patient Care has been discontinued

Frequency of Treatment: _____ BID _____ Daily _____ 1x/Wk _____ 2x/Wk _____ 3x/Wk _____ 1x only _____

_____ Other (Specify) ____________________

Date ____________________ 20_____ **X** ____________________

Physician's Signature