

953 Walnut Street, Suite A
 Wheatland, WY 82201
 (307) 322-1878
 Fax (307) 322-1879

Sandra Sluss, PT
 Stephanie Nelson, PTA

Melissa James, PT
 Kelsey Dooley, PTA
 Lisa Cecil, OT

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

- | | |
|---|--|
| <input type="checkbox"/> Advanced Rehab
<input type="checkbox"/> Braces and Supportive Garments
<input type="checkbox"/> Cardiac Rehab
<input type="checkbox"/> Electric Stimulation
<input type="checkbox"/> TENS
<input type="checkbox"/> EMS
<input type="checkbox"/> HVGS
<input type="checkbox"/> Acuscope
<input type="checkbox"/> Evaluation
<input type="checkbox"/> Gait Training
<input type="checkbox"/> Cane
<input type="checkbox"/> Crutches
<input type="checkbox"/> Walker
<input type="checkbox"/> Weight Bearing Status
Full Partial Non
<input type="checkbox"/> Hot Packs/Cold Packs
<input type="checkbox"/> Home Program
<input type="checkbox"/> Iontophoresis
<input type="checkbox"/> Massage
<input type="checkbox"/> Goals and Objectives
Have been met. | <input type="checkbox"/> Patient care has been discontinued
<input type="checkbox"/> Mobilization
<input type="checkbox"/> Orthotics
<input type="checkbox"/> Paraffin Bath
<input type="checkbox"/> Phonophoresis
<input type="checkbox"/> Pool Therapy
<input type="checkbox"/> Therapeutic Exercise
<input type="checkbox"/> AROM
<input type="checkbox"/> Strengthening
<input type="checkbox"/> Stretching
<input type="checkbox"/> PROM
<input type="checkbox"/> PRE (Resistive)
<input type="checkbox"/> Functional Activities
<input type="checkbox"/> Traction
<input type="checkbox"/> Cervical
<input type="checkbox"/> Lumbar
<input type="checkbox"/> Manual
<input type="checkbox"/> Mechanical
<input type="checkbox"/> Ultrasound
<input type="checkbox"/> Whirlpool
<input type="checkbox"/> Sterile
<input type="checkbox"/> Dressing
<input type="checkbox"/> Debridement |
|---|--|

Other _____

Frequency _____ Duration _____

Goals _____

Precautions _____

Date _____ Signature **X** _____