NORTH PLATTE PHYSICAL THERAPY

MEGHANN MCANDREW PT, DPT
EMILY HILTY, PTA
953 WALNUT ST, UNIT A
WHEATLAND, WY 82201
(307)322-1878/FAX (307)322-1879
LYNDSIE FULLER MSOT, OTR/L

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**
__X__**CARDIAC REBAB**
__X_**ELECTRIC STIMULATION**
___**TENS**
___**EMS**
___**HVGS**
___**ACUSCOPE**
_X__**EVALUATION**
____**GAIT TRAINING**
___**CANE**
___**CRUTCHES**
___**WALKER**
___**WEIGHT BEARING STATUS**
__**FULL**__**PARTIAL**__**NONE**
_X_**HOT/COLD PACKS**
____**HOME PROGRAM**
__X__**IONTOPHORESIS**
_X_**MASSAGE**
____**GOALS/OBJECTIVES HAVE BEEN MET**

____**PATIENT CARE DISCONTINUED**
_X_**MOBILIZATION**
____**ORTHOTICS**
____**PARAFFIN BATH**
___**PHONOPHORESIS**
__X_**POOL THERAPY**
__X_**THERAPEUTIC EXERCISE**
_X_**AROM**
_X_**STRENGTHENING**
_X_**STRETCHING**
_X_**PROM**
_X_**PRE(RESISTIVE)**
___**FUNCTIONAL ACTIVITIES**
____**TRACTION**
___**CERVICAL**
___**LUMBAR**
___**MANUAL**
___**MECHANICAL**
_X_**ULTRASOUND**
____**WHIRLPOOL**
___**STERILE**
___**DRESSING**
___**DEBRIDEMENT**

OTHER: ~~e~~ _____

FREQUENCY 2-3 WKS **DURATION** 4 WKS

GOALS INCREASE FUNCTION/ DECREASE PAIN

PERCAUTIONS PER PROTOCOL

DATE _____ **SIGNATURE** X _____