Physical Therapy ASSOCIATES

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NAME: _____ DATE: _____
PATIENT HOME PHONE: _____ WORK PHONE: _____
DIAGNOSIS: _____
ICD-9 CODE: _____ WORK RELATED: YES NO
PRECAUTIONS/INSTRUCTIONS: _____
FREQUENCY: _____ DURATION: _____

☐ Home Program Only
☐ Outpatient/Home Program
☐ Evaluate and Treat
☐ Wound Care
  ☐ Debridement
  ☐ Dressing Change
☐ Lumbar Traction
☐ Pre-operative Management
☐ Post-operative Management
☐ Unloader
☐ STS Chronic Pain Management
☐ Nerve Conduction Study

MODALITIES:
☐ Intermittent Cervical Traction (ICT)
☐ Cryotherapy
☐ Contrast Hot/Cold
☐ Hot Packs
☐ Elect. Stim. (ES)
☐ Ultrasound
☐ Phonophoresis
☐ Iontophoresis
☐ Massage
☐ Sequential Compression
☐ Whirlpool
☐ Pulsavac
☐ Paraffin Bath
☐ Transdermal Electrical Nerve Stim. (TENS)
☐ Gradient Sequential Compression Pump

EXERCISES:
☐ Aquatic Therapy
☐ AROM
☐ PROM
☐ Strengthening: _____
☐ Stretching: _____
☐ Propriceptive Training
☐ Aerobic Conditioning
☐ Activities of Daily Living (ADL's)
☐ Job Specific Tasks
☐ Low Back Program
☐ Gait Training: _____
☐ Coordination Skills
☐ Physical Reconditioning
☐ Work Hardening
☐ Work Conditioning
☐ Other: _____

PROTOCOLS:
☐ Shoulder I
☐ Shoulder II
☐ Shoulder III
☐ Shoulder IV
☐ Knee I
☐ Knee II
☐ Knee III
☐ Ankle
☐ Elbow I
☐ Elbow II
☐ Wrist
☐ Hand
☐ Hip

I certify that the physical therapy services for the above named patient are or were required:
On an outpatient basis,
Under a plan established and reviewed within 30 days by me as attending physician,
While the patient is or was under my care.

Physician's Signature_____