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Special Instructions:

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Patient Name: ______________________________ Phone: ________________

Referring Physician: __________________________ Date: ________________

Diagnosis: ____

☐ Evaluate & Treat ☐ Continue Current Rx

Pre/Post-Op Rehabilitation

- ☐ Knee
- ☐ Hip
- ☐ Back
- ☐ Shoulder
- ☐ Neck
- ☐ Elbow
- ☐ Wrist/Hand
- ☐ Ankle/Foot

Orthopedic Rehabilitation

- ☐ Strengthening
- ☐ Flexibility/R.O.M.
- ☐ Stabilization
- ☐ Soft Tissue Mobilization
- ☐ Joint Mobilization
- ☐ Other: ______________

Modalities

- ☐ Ultrasound
- ☐ Electrical Stimulation
- ☐ Iontophoresis
- ☐ Traction
- ☐ Other: ______________

Balance Rehabilitation

- ☐ Balance/Vestibular Therapy
- ☐ Canalith Repositioning
- ☐ Neurological Gait Training
- ☐ Other:

Programs

- ☐ Sports Specific
- ☐ FCE
- ☐ Work Conditioning
- ☐ Work Hardening
- ☐ Fitness
- ☐ Osteoporosis
- ☐ Fibromyalgia
- ☐ Neurological
- ☐ Other:

Patient Education

- ☐ Home Exercise Program
- ☐ Fall Prevention
- ☐ ADL Training
- ☐ Other: ______________

Supplies

- ☐ Custom FootMax Orthotics
- ☐ Compression Stockings
- ☐ Braces
- ☐ Other:

Frequency: ________________ Visit(s) per Week

Duration: ________________ Week(s)

Physician Signature: ____ Date______________