

Patient Name: _____ Phone: _____

Referring Physician: _____ Date: _____

Diagnosis: _____

Special Instructions:

Evaluate & Treat

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: _____

Continue Current Rx

Balance Rehabilitation

- Balance Retraining Therapy
- Epley Maneuver (Manual)
- Neurological Gait Training
- NIR Infrared Treatment

Programs

- Balance Retraining
- Vestibular Therapy
- Headaches
- Osteoporosis
- Fibromyalgia
- S/P CVA
- Parkinsons
- Sports Specific
- Work Specific

Patient Education

- Home Exercise Program
- Fall Prevention
- ADL Training
- Other: _____

Frequency: _____ Days per week

Duration: _____ Weeks / Months
circle one

Physician Signature: _____