

**PATIENT INFORMATION**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Date: \_\_\_\_\_  
Diagnosis/Condition: \_\_\_\_\_ ICD9#: \_\_\_\_\_  
Surgical Procedures: \_\_\_\_\_

**INSTRUCTIONS:**

EVALUATE AND TREAT EVALUATION	GAIT ANALYSIS BIOFEEDBACK	CONTACT BEFORE COMMENCING WITH TREATMENT
JOB SITE ANALYSIS	REPLACEMENT SCREENING	FUNCTIONAL CAPACITY

**TREATMENT GOALS:**

INCREASE R.O.M.	INCREASE MOBILITY	INCREASE GENERAL FITNESS
INCREASE STRENGTH	DECREASE PAIN	IMPROVE PATIENT & FAMILY EDUCATION
IMPROVE FUNCTION	DECREASE EDEMA	

**MODALITIES:**

HEAT	ELECTRICAL STIMULATION	IONTOPHORESIS
COLD	VASOPNEUMATIC COMPRESSION	PARAFFIN BATH
WHIRLPOOL	FLUIDOTHERAPY	ULTRASOUND

**PROCEDURES:**

MASSAGE/SOFT TISSUE MOB.	McKENZIE/WILLIAM'S EXERCISE	ORTHOTICS/SPLINTS
MOBILIZATION	THERAPEUTIC/ISOKINETIC EXERCISE	STABILIZATION
TRACTION	TENS (HOME USE)	PREVENTIVE BACK/NECK CLASSES
WORK CONDITIONING	TRANSITIONAL WORK PROGRAM	FITNESS CONDITIONING PROGRAM
JOB COACHING		

**TREATMENT PLAN:**

THERAPIST'S DISCRETION

DURATION OF TREATMENT UP TO	TIMES PER WEEK X	WEEKS
FREQUENCY OF TREATMENT	1    2    3    4	5    (DAYS PER WEEK)

**ADDITIONAL COMMENTS:**

I hereby certify that the services indicated above are medically necessary.

PHYSICIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_ PHONE: \_\_\_\_\_