



BLAINE • EAGAN • LAKEVILLE • MIDWAY • MINNETONKA • PLYMOUTH • VADNAIS HEIGHTS • WOODBURY

PATIENT INFORMATION

NEW ORDER/PLAN OF CARE

UPDATED PLAN OF CARE

Patient Name: _____ DOB: ____/____/____

Treatment Diagnosis: _____

Date of Injury/Surgery: _____ Patient is aware of diagnosis and prognosis? Y or N

Insurance: _____

Home Telephone Number (____) _____ - _____

Work Telephone Number (____) _____ - _____

Cell Telephone Number (____) _____ - _____

Contraindications/Precautions: _____

Patient is in need of an interpreter? Yes No If yes, please specify language: _____

Bring this prescription and insurance information to your first visit.

EVALUATE & TREAT

PHYSICAL/OCCUPATIONAL THERAPY

HAND THERAPY

Frequency and Duration determined by patient progress and therapist discretion: Up to _____

Visits: Frequency/Duration 1 2 3 4 5 x/week for _____ weeks Up to _____ visits

Treatment Goals:

+ ROM + Strength - Pain - Swelling + Flexibility Restore Function Desensitization

Procedures

- Range of Motion PROM AROM AAROM
- Edema Control
- Joint Mobilization
- Manual Therapy TFM MFR STM
- Tool Assisted STM (Graston)
- Neuromuscular RE-Education
- Scar Management

Exercise Programs

- Back Rehabilitation/Neck Rehabilitation
- Shoulder Rehabilitation
- Elbow Rehabilitation
- Wrist/Hand Rehabilitation
- Knee Rehabilitation
- Ankle Rehabilitation
- Gait Training
- Strengthening/Conditioning
- Home Exercise
- Posture/Body Mechanics Training
- Pre-Op Exercise

Modalities

- As Indicated
- Ultrasound
- Phonophoresis (10% Hydrocortisone)
- Traction
- Electrical Stim (TENS IFC EGS FES)
- Iontophoresis (Dexamethasone 4mg/ml)
- Strengthening
- Fluidotherapy
- Paraffin

Splint/Orthosis

- Describe _____
- Dynamic Static
- Elbow Forearm/Wrist Hand

Specialty Programs

- Dancers Runners Throwers
- Spinecare Golf Fitness

PROVIDER INFORMATION

Date: ____/____/____ Referring Provider Name: _____

Referring Provider Signature: _____ UPIN / NPI: _____

Phone: (____) _____ - _____ Fax: (____) _____ - _____