North DeKalb Orthopedics pc

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PHYSICAL THERAPY REFERRAL

Patient_____**Date**_____
Diagnosis_____

☐ Evaluate and Treat

TREATMENT

- ☐ Back School ☐ Neck School
- ☐ McKenzie Program
- ☐ Exercise Program
- ☐ Home Program
- ☐ Maintenance Program
- ☐ Gait Training ☐ Crutch Use
- ☐ Shoulder Strengthening (Rotator Cuff)
- ☐ Joint Mobilization/ Range of Motion
- ☐ Patellar Mobilization
- ☐ Quad and VMO Strengthening
- ☐ Terminal Extension Exercises
- ☐ Hip Abductor Stretching & Strengthening
- ☐ Ankle Strengthening (Peroneals)
- ☐ Active ROM (_____-_____º)
- ☐ Passive ROM (_____-_____º)
- ☐ Progressive Resistive Exercises
- ☐ Neuromuscular Re-Education
- ☐ Isokinetic Evaluation
- ☐ Biodex/Cybex
- ☐ KT 1000/2000 testing
- ☐ Activities of Daily Living
- ☐ Aquatic Therapy
- ☐ Prophylactic Strapping
- ☐ Nutritional Consultation

MODALITIES

- ☐ Ultrasound
- ☐ Electrical Stimulation
- ☐ Moist Heat
- ☐ Whirlpool
- ☐ Massage
- ☐ Cryotherapy
- ☐ TENS
- ☐ Contrast Bath
- ☐ Phonophoresis
- ☐ Iontophoresis
- ☐ Traction
- ☐ Intermittent Compression
- ☐ Sterile Whirlpool
- ☐ Paraffin Bath
- ☐ Fluidotherapy
- ☐ Re-evaluation
- ☐ Functional Activities
- ☐ Soft Tissue Mobilization
- ☐ JOBST Pump

BRACING

- ☐ Lenox Hill
- ☐ Townsend ACL
- ☐ Other_____

FOR HOME USE

- ☐ Cervical Pillow
- ☐ Cervical Traction
- ☐ Lumbar Corset
- ☐ Lumbar Traction
- ☐ Lumbar Cushion
- ☐ Foot Orthotics
- ☐ TENS
- ☐ Overhead Pulley

HAND Rehab (O.T.)

- ☐ Evaluate & Treat
- ☐ Dexterity
- ☐ Desensitization
- ☐ Edema Control
- ☐ Flexor Tendon Program
- ☐ Extensor Tendon Program

OTHER

- ☐ Work Hardening
- ☐ Functional Capacity Evaluation
- ☐ Impairment Rating

OTHER_____

FREQUENCY:_____**visits per week** _____**weeks.**

Physician's Signature_____
I hereby certify these services as medically necessary for the patient's plan of care.

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