Pro-Active Physical Therapy
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Physical Therapy Referral Form & Plan of Care

Patient Name: _____ **Date:** _____

Diagnosis: _____ **ICD-9:** _____

Precautions: _____ **Next MD Appt:** _____

Frequency: ☐ 1xWk ☐ 2xWk ☐ 3xWk ☐ 5xWk **Duration:** ☐ 2 Wks ☐ 4 Wks ☐ 6 Wks ☐ Other: _____

☐ Evaluate and Treat ☐ Continue Plan of Care

Treatment

Modalities
- ☐ Hot Packs
- ☐ Cold Packs
- ☐ Ultrasound
- ☐ Paraffin
- ☐ Iontophoresis
- ☐ Phonophoresis
- ☐ Electrical Stimulation
- ☐ TENS
- ☐ Neuromuscular E-Stim
- ☐ Laser Light Therapy

Therapeutic Exercise
- ☐ Range of Motion
  - ☐ Passive
  - ☐ Active-Assistive
  - ☐ Active
- ☐ P.R.E.'s
- ☐ Strengthening
- ☐ Stabilization
- ☐ Flexibility
- ☐ Home Exercise Program
- ☐ ATM 2

Manual Therapy
- ☐ Massage
- ☐ Myofascial Release
- ☐ Joint Mobilization
- ☐ Muscle Energy Tech.
- ☐ Edema Management
- ☐ Scar Management
- ☐ Strain / Counter strain

Muscle Testing/Training
- ☐ Isokinetic Testing
- ☐ Isokinetic Training
- ☐ Isometric Testing
- ☐ Isometric Exercise
- ☐ Computerized Balance Testing
- ☐ Computerized Balance Training

Protocols / Programs

Lower Extremity
- ☐ Ankle Sprain / Strain
- ☐ MCL / LCL Sprain
- ☐ Meniscus Tear / Repair
- ☐ Arthroscopy
- ☐ Lateral Release
- ☐ Patellar Subluxation
- ☐ ACL Tear / Reconstruction
- ☐ Anterior Knee Pain
- ☐ Total Knee Replacement
- ☐ Total Hip Replacement

Shoulder / Elbow
- ☐ Shoulder Impingement
- ☐ Shoulder Dislocation
- ☐ Capsular / Labral Repair
- ☐ Rotator Cuff Repair
- ☐ Shoulder Instability
- ☐ Medial Epicondylitis
- ☐ Lateral Epicondylitis
- ☐ UCL Tear / Repair
- ☐ Ulnar Nerve Transposition
- ☐ Carpal Tunnel Syndrome

Spine
- ☐ Decompression Traction
  - ☐ Cervical
  - ☐ Lumbar
- ☐ Isometric Trunk Stabilization
- ☐ Extension Exercises
- ☐ Flexion Exercises
- ☐ Thoracic Stabilization
- ☐ Cervical Stabilization
- ☐ Scapular Stabilization

Other
- ☐ Vestibular Rehab
- ☐ BPPV / Eply's Maneuver
- ☐ Bladder Retraining
- ☐ Pelvic Pain
- ☐ Biomechanical Eval
- ☐ Custom Orthotics
- ☐ Gait Training

  WB Status: ☐ ____%WB
  ☐ FWB ☐ TTWB
  ☐ PWB ☐ WBAT

☐ Other: _____

☐ Verbal Order: Date:_____ Therapist Signature:_____

I certify that the physical therapy services and plan of care for the above named patient are medically necessary and that the plan of care will be reviewed at least every 30 days.

PHYSICIAN'S SIGNATURE:_____ **DATE:**_____

We are located on the corner of Bruce B. Downs Blvd and 138th Avenue, 1 block north of University Community Hospital.

www.pro-activephysicaltherapy.com