ccess Physical Therapy

Name: _____

Phone: _____ Date: _____

Diagnosis: _____

Frequency: _____ Times Per Week For _____ Weeks

_____ Evaluate And Treat Per Therapist Discretion

Referring Medical Provider: _____

Additional Comments/Instructions: _____

_____

Therapeutic Exercises
____ Strengthening/Conditioning Exercises
____ Home Exercise Program
____ Lower Extremity Strengthening/Stretching
____ Upper Extremity Strenghtening/Stretching
____ Abdominal/Pelvic Stabilization
____ Cervical Strengthening/Stretching
____ Lumbar Strengthening

Hand Therapy & Occupational Therapy
____ Evaluate & Tx.
____ Custom Splint/Evaluate & Tx.

Modalities
____ Hot/Cold Packs
____ Ultrasound
____ Electrical Stimulation/TENS
____ Iontophoresis
____ Phonophoresis
____ Mechanical Cervical Traction
____ Mechanical Lumbar Traction

Manual Therapy
____ Soft Tissue Mobilization/Massage
____ Joint Mobilization
____ PNF

Work Rehabilitation
____ Work Conditioning
____ Work Hardening
____ Functional Capacity Evaluation

IN MAKING THIS REFERAL MEDICAL PROVIDER CERTIFIES
THAT PRESCRIBED REHABILITATION IS A MEDICAL NECESSITY

Access Physical Therapy

www.acctherapy.com

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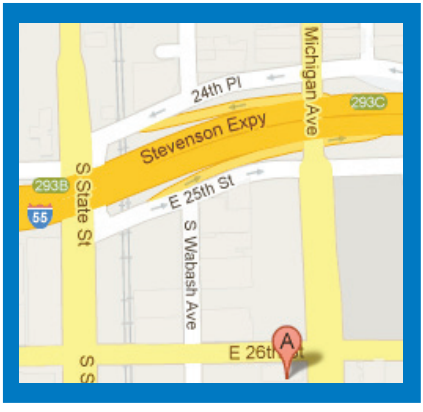

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