



Physical Therapy Order

Date ____/____/____ Referring Physician _____

Patient Name _____ DOB ____/____/____

Diagnosis / ICD-9 _____ Right or Left (if applicable)

_____ Evaluate and Treatment _____ times per week for _____ weeks

_____ Continue Current Treatment _____ times per week for _____ weeks

_____ Strengthen, Stretch, Range of Motion, teach home exercise

_____ Range of motion precautions (*Active & Passive will be done otherwise*):

_____ Modalities per Therapist Discretion (Ultrasound, electrical stimulation, ice, heat, etc.)

_____ Weight bearing precautions

_____ Other instructions _____

Physician Signature _____

(map on reverse)

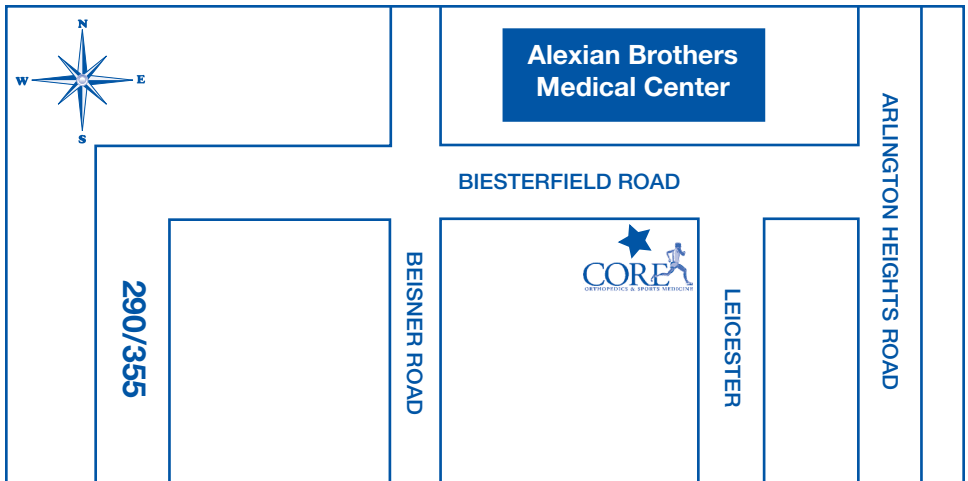


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Wheelchair Accessible



We are conveniently located across the street from the Alexian Brothers Hospital campus on the corner of Biesterfield & Leicester.

Convenient morning and evening hours.

We gladly accept: BCBS PPO, Aetna PPO/POS, PHCS, Humana PPO/POS, EPO, UHC PPO/Choice Plus/Select Choice Plus & Workman's Comp