CORE
ORTHOPEDICS & SPORTS MEDICINE

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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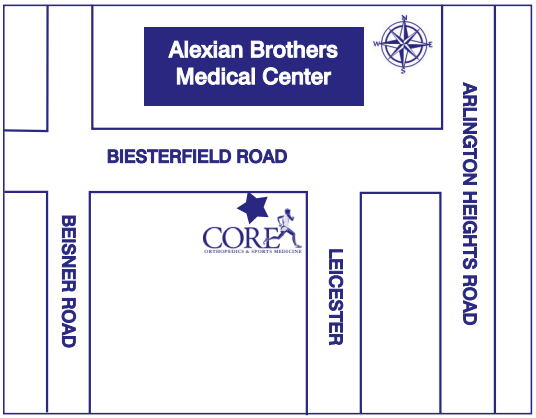
Main Phone: 1-847-690-9360
Fax: 1-847-690-0372



555 Biesterfield Road
2nd Floor
Elk Grove Village, IL 60007

2380 Lakewood Blvd.
Hoffman Estates, IL 60192

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.

Wheelchair Accessible