Patient Name:______________________________________**Phone and/or email:**_______________________________________

Diagnosis and/or ICD-10: ____

Relevant Clinical Findings/Co-morbidities: ____

Physical Therapy Treatment Order (check):

☐ Evaluation and Treatment per PT discretion

☐ Extremity Joint Mobilization
☐ Therapeutic Exercise
☐ Therapeutic Activity
☐ Spinal Mobilization
☐ Myofascial Release

☐ Customized Orthotics
☐ Neuromuscular Re-education
☐ Posture/Body Mechanics Education/Training
☐ Spinal Stabilization
☐ Modalities: Electrical Stimulation, Ultrasound

Other Instructions: ____

Duration (check):
☐ As appropriate with progress
☐ ___ number of visits
☐ Other:_________________________________
☐ *Per PT discretion*

Frequency (check):
☐ 1-2 days/week
☐ 2-3 days/week
☐ Other: ____
☐ *Per PT discretion*

Physician Follow Up Plan:
☐ Date _____________
☐ Provide periodic progress report
☐ Send summary of evaluation
☐ Other: ______________________________________

Pertinent Intervention History
☐ Surgery ☐ Diagnostic reports ☐ Imaging ☐ Injections ☐ Other

Please describe: ____

Comments/Special Instructions/Precautions:

____

____

Midwest Physical Therapy LLC

Physician Name:________________________**Physician NPI:**_________________**Clinic Name:** _____________________

Clinic Address: ____

Phone Number:__________________________________**Fax Number:**____

____

Physician Signature **Date**

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More Forms Available to Print: www.tcpaintherapist.com