



Spine, Sports & Orthopedic Rehabilitation

6180 West Michigan Ave.
Pittsfield Twp., MI 48108
Ph: (734) 434-8800
Fx: (734) 434-8811

5417 Whittaker Road
Ypsilanti, MI 48197
Ph: (734) 483-9200
Fx: (734) 483-9202

Patient Name _____ Date _____

Referring Physician _____

Diagnosis _____

Frequency _____ X per week for _____ weeks

Precautions _____

PHYSICAL THERAPY

- Evaluation & Treatment
- Therapeutic Exercise
- Balance / Gait Training
- Orthotic Evaluation
- Functional Training
- Work Conditioning
- Other (specify) _____

POOL THERAPY

- Evaluation & Treatment
- THA protocol
- TKA protocol
- TSA protocol
- Spinal Fusion / laminectomy protocol
- Pelvic reconstruction
- O.R.I.F. (area) _____
- Other (specify) _____

MODALITIES

- | | |
|--|--|
| <input type="checkbox"/> Manual Therapy | <input type="checkbox"/> Ultrasound |
| <input type="checkbox"/> Soft Tissue Mobilization | <input type="checkbox"/> E—stim / I.F.C. |
| <input type="checkbox"/> Therapeutic Massage | <input type="checkbox"/> Ionto/Phonohoresis |
| <input type="checkbox"/> MFR, S-CS, C-S | <input type="checkbox"/> TENS / MENS |
| <input type="checkbox"/> Trigger Point / Spray n Stretch | <input type="checkbox"/> Ice Pack / Hot Pack |
| <input type="checkbox"/> Cervical / Lumbar Traction | <input type="checkbox"/> Infra-red / laser |
| <input type="checkbox"/> Lumbar Decompression | <input type="checkbox"/> Other _____ |

PHYSICIAN SECTION

- Request P.T. progress note monthly
- Request P.T. progress note & verbal report monthly
- Other _____

Physician's Signature _____

Additional Comments: _____
