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Champaign, IL 61820
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Patient Name: _____ **Date of Birth:** ___ / ___ / ___ **Today's Date:** ___ / ___ / ___

Primary ICD9: _____ **Diagnosis:** _____ ; **Secondary ICD9:** _____ **Diagnosis:** _____

Precautions: _____

Referral for: ___ Physical Therapy ___ Occupational Therapy

Treatment Recommendations: ___ Evaluate and Treat

- | | | |
|---|--|--|
| <input type="checkbox"/> Therapeutic Exercise | <input type="checkbox"/> Lontophoresis (Dexamethasone) | <input type="checkbox"/> Aquatic Therapy |
| <input type="checkbox"/> Manual Therapy | <input type="checkbox"/> Ultrasound | <input type="checkbox"/> Paraffin |
| <input type="checkbox"/> Therapeutic Activities | <input type="checkbox"/> Gait Training | <input type="checkbox"/> Phonophoresis |
| <input type="checkbox"/> Home Exercise Program | <input type="checkbox"/> Splinting | <input type="checkbox"/> Infrared |
| <input type="checkbox"/> Neuromuscular Re-education | <input type="checkbox"/> Whirlpool | <input type="checkbox"/> Ice/Heat |
| <input type="checkbox"/> Electrical Stimulation | <input type="checkbox"/> TENS | <input type="checkbox"/> Pelvic Floor |
| | | <input type="checkbox"/> Other: _____ |

Comments: _____

Frequency and Duration: _____ times per week for _____ weeks or _____ visits.

Physician Signature

Name Printed

Phone