



**ORTHOPEDIC
& TMJ
PHYSICAL
THERAPY
CENTER**

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PHYSICAL THERAPY ORDERS

PATIENT'S NAME: _____ Phone: _____ Date: _____

Diagnosis/Condition: _____ ICD-10 code(s) _____

Surgical procedures &/or precautions: _____

TREATMENT GOALS

- | | | |
|--|--|---|
| <input type="checkbox"/> Decrease pain | <input type="checkbox"/> Decrease edema | <input type="checkbox"/> Improve posture & movement mechanics |
| <input type="checkbox"/> Increase ROM | <input type="checkbox"/> Improve relaxation skills | <input type="checkbox"/> Restore normal tongue positioning |
| <input type="checkbox"/> Increase strength | <input type="checkbox"/> Home exercise program | <input type="checkbox"/> Urinary retention |
| <input type="checkbox"/> Improve function | <input type="checkbox"/> Increase understanding | <input type="checkbox"/> Restore pelvic floor integrity |

INSTRUCTIONS

- | | | | |
|---|-------------------------------------|--|---------------------------------|
| <input type="checkbox"/> Evaluate and treat | <input type="checkbox"/> Evaluation | <input type="checkbox"/> Report by phone | <input type="checkbox"/> Letter |
|---|-------------------------------------|--|---------------------------------|

Modalities: Heat Cold Elec. Stim Ultrasound Other _____

Procedures: Exercise Manual Therapy Traction Massage sEMG

Movement mechanics Iontophoresis Phonophoresis

TREATMENT PLAN PER LETTER OF

- Therapist's discretion
- Frequency of treatment ___days/week
- Duration of treatment: _____ week(s),
- Visits: _____ other _____

Additional Comments: _____

REFERRED BY: _____

Degree

THANK YOU FOR YOUR REFERRAL