



# WESTCHASE PHYSICAL THERAPY & MEDICAL SUPPLY

## REFERRAL / CARE PLAN

PATIENT: \_\_\_\_\_

DIAGNOSIS: \_\_\_\_\_

### EVALUATE AND TREAT AS INDICATED

#### PROTOCOLS

- Back/Neck Program
- Knee Program
- Shoulder Program
- Post Arthroscopic Program
- Flexor Tendon Program
- TMJ Protocol
- Hand/Wrist Program

#### HYDROTHERAPY

- Hot Packs
- Cold Packs/Cryotherapy
- Whirlpool
- Paraffin Bath

#### ELECTROTHERAPY

- Ultrasound
- Electrical Stimulation
- Iontophoresis
- TENs
- Jobst Compression
- Traction \_\_\_\_\_ lbs.  
\_\_\_\_\_ Pelvic  
\_\_\_\_\_ Cervical

#### THERAPEUTIC EXERCISES

- Passive Range
- Active
- Isometric
- Progress Resistive

#### MANUAL THERAPIES

- Joint Mobilization
- Spine Mobilization
- Myofascial Release
- Soft Tissue Mobilization

#### GOALS

- Decrease Pain
- Decrease Edema
- Increase ROM
- Increase Strength
- Improve Function
- Improve Posture

#### MISCELLANEOUS

- Gait Training
- Prosthetic/Orthotic Training
- Shoulder Program

Special Instructions/Precautions: \_\_\_\_\_

Frequency: (Circle) Daily 2x/Week 3x/Week Other: \_\_\_\_\_ Duration: \_\_\_\_\_

Durable Medical Equipment / Medical Supplies: \_\_\_\_\_

Attending Physician: \_\_\_\_\_ Date: \_\_\_\_\_

I certify that the above services are required and authorized by me and that this plan of care will be reevaluated every 30 days.