Priority Physical Therapy, Inc.
Health Is Our Priority; Make It Yours.

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Patient
Name: _____ DOB: _____

Diagnosis: _____

Precautions: _____

Initial Evaluation and Treatment: ☐ **Physical Therapy** **Or** ☐ **Occupational Therapy**

Other Recommendations:

- ☐ Therapeutic Exercise
- ☐ Balance/Neuromuscular Re-ed
- ☐ Gait Training
- ☐ Manual Therapy
  - ☐ Myofascial / Soft tissue Mobs
  - ☐ Joint Mobs / Manipulations
  - ☐ ASTYM
  - ☐ Visceral Manipulation
- ☐ Women's / Men's Health
  - ☐ Incontinence
  - ☐ Pelvic Pain
  - ☐ Pregnancy / Postpartum
  - ☐ Osteoporosis
  - ☐ Pre / Post Breast Surgery
  - ☐ Lymphedema Management
    - ☐ Manual Lymphatic Drainage
    - ☐ Compression Bandaging
- ☐ Hand, Elbow, Wrist Rehabilitation
- ☐ TMJ Rehabilitation
- ☐ Vestibular Rehabilitation
- ☐ Work Rehab / Work Conditioning
- ☐ DME-POS ☐ Custom ☐ Off-the-shelf
  - ☐ Bracing _____
  - ☐ Splinting _____
- ☐ Mechanical Traction
  - ☐ Home Unit
- ☐ Electrical Stimulation
  - ☐ Pain / Spasm / Edema
  - ☐ Muscle Re-ed
  - ☐ TENS ☐ Home Unit
  - ☐ Iontophoresis w/dexamethasone
- ☐ Ultrasound
  - ☐ w/Dexamethasone gel
- ☐ Paraffin
- ☐ Fluidotherapy

Referring Provider
Signature: _____ Date: _____