McLaren
CARO REGION

RENUE
PHYSICAL THERAPY

PHYSICAL THERAPY OUTPATIENT REQUEST FORM

PHONE (989) 672-5112
FAX (989) 673-3005

PATIENT'S NAME:_____ DATE:_____

DIAGNOSIS:_____

TREATMENT SCHEDULE

FREQUENCY 1 2 3 4 5 times per week; **DURATION** 1 2 3 4 5 6 7 8 weeks

_____ Hot Packs
_____ Ultrasound
_____ Massage
_____ Phonophoresis
_____ Joint Mobilization
_____ Soft Tissue Release
_____ Iontophoresis
_____ Ice
_____ Cervical Traction
_____ Pelvic Traction
_____ Whirlpool
_____ Contrast Bath
_____ Paraffin
_____ Myofascial Release

_____ T.E.N.S
_____ Elect. Stim
_____ ROM
____ Passive
____ Active Assisted
____ Active

_____Gait Training
_____ Crutch/Walker Training
_____ Non Weight Bearing
_____ Partial Weight Bearing
_____ Full Weight Bearing

_____ Exercise
_____ M^C Kenzie
_____ William Type
_____ Postural
_____ Isometric
_____ Progressive Resistive
_____ Stretching
_____ Other _____

Special Instructions:

_____

_____

_____

_____

Physical Therapy Use Only

P.T. Evaluation Date _____

_____
Physical Therapist Signature

_____ Treat Only As Written

_____ Authorization To Use Alternate Procedures

_____
Physicians Signature Date

FORM: PT 10
REV: 3-28-18