Medical Center *Edmond*

EDMOND PHYSICAL THERAPY

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www.oumedicine.com/EdmondPT

Patient Name: ______________________________

Diagnosis: ______________________________

Frequency: ____________ x week Duration: ____________ weeks

☐ **EVALUATE & TREAT AS INDICATED**

(Orders for evaluate and treat, iontophoresis, or phonophoresis may include the topical use of Lidocaine 4% solution, 10% hydrocortisone in ultrasonic gel, or Dexamethasone)

MODALITES

- ☐ Ice
- ☐ Moist Heat
- ☐ Ultrasound
- ☐ TENS
- ☐ Electrical Stimulation
- ☐ Iontophoresis
- ☐ Phonophoresis
- ☐ Traction
- ☐ Massage
- ☐ Fluidotherapy
- ☐ Paraffin Bath
- ☐ Vasopneumatic Compression

EXERCISE/OTHER

- ☐ Passive ROM
- ☐ Active Assistive ROM
- ☐ Active ROM
- ☐ Strengthening - PRE
- ☐ Spinal Stabilization
- ☐ Manual Therapy
- ☐ Gait Training
- ☐ Proprioception
- ☐ Home Program
- ☐ Lymphedema CDT
- ☐ Vestibular Rehabilitation
- ☐ Working Conditioning
- ☐ Hand Therapy

Special Instructions ______________________________

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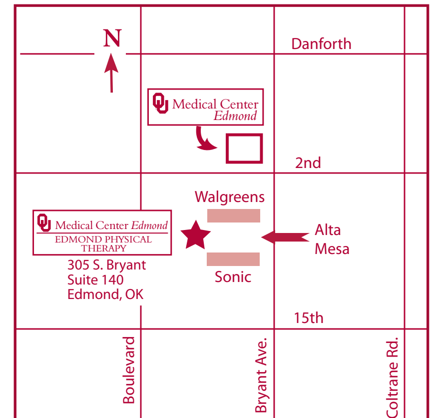
Physician's Signature **Date**



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