CREATIVE THERAPEUTICS
PHYSICAL THERAPY

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PHYSICIAN ORDERS

Patient's Name _____ Date _____

DOB: _____ Date of Injury/Surgery _____

DIAGNOSIS

GOALS

PRECAUTIONS

FREQUENCY/DURATION

EQUIPMENT NEEDS

☐ **Physical Therapy Evaluation/ Treatment**

MODALITIES
- ☐ Heat / Ice
- ☐ Ultrasound
- ☐ Iontophoresis
- ☐ Traction
- ☐ Electrical Stim
- ☐ Diathermy

PROCEDURES
- ☐ Soft Tissue Mobilization
- ☐ Joint Mobilization
- ☐ Spinal Mobilization
- ☐ Neuromuscular Re-education
- ☐ Neural Tension
- ☐ PNF
- ☐ Active / Passive ROM

THERAPEUTIC EXERCISES
- ☐ Spinal Stabilization
- ☐ Prenatal / Postnatal
- ☐ Flexibility
- ☐ Postural Reeducation
- ☐ Physioball
- ☐ Foam Roll
- ☐ Osteoperosis
- ☐ Pelvic Floor Re-education
- ☐ Strengthening

Recheck in _____ weeks

_____ _____

Date Physician's Signature

Thank You very much for the Referral

Please have the doctor sign, print and date, along with indicating the frequency and duration of PT for this patient. Please include the demographics, so that we may contact this patient for an appointment. If the patient has an HMO insurance plan for either **TMJ** or **Pelvic Floor**, please have the SANTE authorization included.