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# OUT PATIENT THERAPY

Patient: _____ Date: _____

DX: _____

Pat. Contact # _____

Instructions: _____

| ❒ Occ. Therapy ❒ Phys. Therapy | ❒ Speech Therapy |
|---|---|
| ❒ **Evaluate and Treat** | ❒ Dysphagia |
| ❒ RCR: post op program ❒ PROM only | ❒ Voice / Fluency |
| ❒ ACL: post op program | ❒ Dysarthria |
| ❒ Knee arthroscopic program | ❒ Cognitive linguistic |
| ❒ TKR: post op program | ❒ Speech / Language |
| ❒ Neck Surgery: post op program | ❒ Modified Barium Swallow |
| ❒ Back Surgery: post op program | |
| ❒ Back: Non-Surg | |
| ❒ Neck: Non-Surg | |
| ❒ CVA / Neuro Re-ed | |

❒ Modalities as needed ❒ US ❒ Elect. Stim

❒ **Wound care/debridement** ❒ Moist Heat ❒ Cold Pack

❒ Intermittent Cervical / Pelvic Traction ❒ Ionto ❒ Phonophoresis

❒ Needling

❒ Gait: ❒ FWB ❒ PWB ❒ TDWBAT ❒ NWB

**Frequency:**

❒ 1 Visit only ❒ 2 x week ❒ 3 x week

**Duration:**

❒ 1 week ❒ 2 weeks ❒ 3 weeks ❒ 1 month

_____

Physician Signature (date & time)

_____

Physician Printed Name