PHYSICAL THERAPY
Cascade

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Patient Name:_____Date:_____

Diagnosis:_____Phone:_____

Surgical Procedure:_____

Precautions or Special Instructions:_____

☐ **Evaluate and Treat at Therapist's Discretion**

☐ **Therapeutic Exercise**
- ☐ Strengthening
- ☐ Stretching
- ☐ AAROM
- ☐ Home Exercise Program
- ☐ Back Stabilization
- ☐ Cardiovascular Conditioning

☐ **Manual Therapy**
- ☐ Massage/Soft Tissue Mobilization
- ☐ PROM/Stretching
- ☐ Joint Mobilization
- ☐ Myofascial Release

☐ **Traction**
- ☐ Cervical
- ☐ Lumbar

☐ **Wound Care**
- ☐ Sterile Whirlpool
- ☐ Debridement

☐ **Modalities**
- ☐ Heat / Ice
- ☐ Ultrasound
- ☐ Electrical Stimulation
- ☐ T.E.N.S.
- ☐ N.M.E.S.
- ☐ Iontophoresis/Phonophoresis
- ☐ Whirlpool
- ☐ Paraffin Bath

☐ **Other**
- ☐ Gait Training
- ☐ Work Hardening/Conditioning
- ☐ Prosthetic Training
- ☐ Stroke Rehabilitation
- ☐ Neuromuscular Re-education
- ☐ Custom Foot Orthotics
- ☐ _____
- ☐ _____

Frequency: _____ times per week for _____weeks

☐ This physical therapy is an attempt to prevent hospitalization or surgery.
☐ This physical therapy is post surgery, which has shortened the patient's hospital stay.

I CERTIFY THAT THE ABOVE TREATMENT PLAN IS MEDICALLY NECESSARY.

Physician's Signature_____Date_____