SUMMIT Physical Therapy

Physical, Occupational & Speech Therapy Specialists

❖ Claremore, Catoosa & Pryor ❖

www.ptsummit.com

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Patient Name: _____ Phone_____

Date of Onset: _____ Next Dr. Appt: _____ ICD-10 Code:_____

Diagnosis: _____ Weight Bearing Status: _____

Evaluate and Treat as Indicated: _____PT _____OT _____ST

Special Instructions/Precautions: _____

_____

Rehabilitation Programs: ☐ Neck ☐ Back ☐ Shoulder ☐ Hand ☐ Elbow ☐ Hip ☐ Knee ☐ Foot/Ankle ☐ Stroke ☐ Spine ☐ Balance ☐ Gait Training ☐ Aquatic Therapy

MODALITIES

- ☐ Modalities as Indicated
- ☐ Electrical Stimulation
- ☐ Ultrasound/Phono
- ☐ Iontophoresis
- ☐ Tens Application
- ☐ Traction Neck/Back
- ☐ Massage
- ☐ Soft Tissue Mobilization
- ☐ Whirlpool
- ☐ Wound Care _____

EXERCISES

- ☐ Passive
- ☐ Active Assistive
- ☐ Active
- ☐ Resistive
- ☐ Mobilization
- ☐ Stretching
- ☐ Isometrics
- ☐ Muscle Strengthening (PRE)
- ☐ Gait Training
- ☐ Home Exercise Instruction

☐ **ISOKINETIC EVALUATION**

☐ **FUNCTIONAL CAPACITY EVALUATION**

☐ **WORK CONDITIONING**

☐ **HAND THERAPY**
- ☐ **CHT**

☐ **HAND SPLINTING**
- ☐ **STATIC**
- ☐ **DYNAMIC**

☐ **CUSTOM FOOT ORTHOTICS**

☐ **DRY NEEDLING**

- ☐ Daily
- ☐ Three times a week
- ☐ Treatment Goals as per therapist's discretion unless otherwise noted below

Other _____

_____

Frequency (times per week): ☐1 ☐2 ☐3 ☐4 ☐5

Duration (in weeks): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6

Signature certifies the established plan of care.

Physician Signature: _____Date: _____

Physician's Name (printed):_____