ATLAS PHYSICAL THERAPY

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Patient Name: _____ Date_____

DOB: _____ DOI: _____ DOS: _____

Diagnosis/ Procedure: _____

Precautions or Specific Requests: _____

❑Evaluate & Treat ❑Treat only as specified below

Manual Therapy	*Therapeutic Exercise*	*Modalities*	*Home Exercise Program*	*Protocols*
❑Soft Tissue Rehab	❑Active ROM	❑Electrical Stimulation	❑Flexibility/ Stretching	❑McKenzie
❑Joint Mobilization Stabilization	❑Active Assistive ROM	❑Neuromuscular Re-education	❑Isometrics	❑Lumbar
❑Manual Traction	❑Passive ROM	❑Cold Pack	❑Strengthening	❑Gait Training
❑Myofascial Release Training	❑Resistive	❑Ice Massage	❑Thera band	❑Balance
❑Scar Mobilization	❑Isometric	❑Ultrasound	❑Pre Op/ Post Op	❑Kinesiotaping
❑Dry Needling	❑Gait Training	❑Iontophoresis		
		❑Phonophoresis		
		❑TENS (Rental/ Purchase)		
		❑NMES (Rental/ Purchase)		

Medical Information: ❑Pre- Op ❑Post Op

Work Status: ❑Full duty ❑Light Duty ❑None

Weight Bearing Status: ❑ Full ❑Toe Touch ❑Partial _____% ❑As Tolerated ❑Non Weight Bearing

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Frequency: ❑ **1 X weekly** ❑ **2 X weekly** ❑**3 X weekly** ❑ **Daily** ❑**Custom**

Duration: ❑ **1 week** ❑ **2 weeks** ❑**3 weeks** ❑**4 weeks** ❑**Custom**

This order is an evaluate and treat order unless specified above

I CERTIFY THAT THE ABOVE TREATMENT PLAN IS MEDICALLY NECESSARY AND APPROVED

_____ _____

SIGNATURE **DATE**

_____

PRINTED NAME