Total Care Rehab
PHYSICAL THERAPY

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Granger, IN 46530

Physical Therapy/Occupational Therapy Order

Patient Name _____

Diagnosis/ICD-10 code _____

☐ Evaluate and Treat

☐ Therapeutic exercise

PROM/AAROM/AROM/PRE

☐ Neuromuscular re-education

Posture/Stabilization/Balance

☐ Therapeutic activity

☐ Modalities

E-stim/Ultrasound/Cold pack/Heat pack

☐ Manual Therapy

☐ Physical performance tests

☐ Gait training

☐ HEP Instruction

Special Instructions/ Precautions _____

Patient to be seen _____x's a week times _____ weeks. I hereby certify that the above order is medically necessary.

_____ _____

Physicians signature Date

_____ _____

Printed Name Telephone