SUMMIT ORTHOPEDICS

BLAINE • EAGAN • LAKEVILLE • MIDWAY • MINNETONKA • PLYMOUTH • VADNAIS HEIGHTS • WOODBURY

# THERAPY REFERRAL

Therapy Referrals: (651) 968–5903

Appointments: call (651) 968–5201

or schedule online at summitortho.com/schedule

## PATIENT INFORMATION ☐ NEW ORDER/PLAN OF CARE ☐ UPDATED PLAN OF CARE

Patient Name:_____ DOB: _____ /_____ /_____

Treatment Diagnosis:_____

Date of Injury/Surgery:_____ Patient is aware of diagnosis and prognosis? Y or N

Insurance:_____

Home Telephone Number (____) _____-_____

Work Telephone Number (____) _____-_____

Cell Telephone Number (____) _____-_____

Contraindications/Precautions: _____

*Bring this prescription and insurance information to your first visit.*

## EVALUATE & TREAT ☐ PHYSICAL/OCCUPATIONAL THERAPY ☐ HAND THERAPY

☐ **Frequency and Duration determined by patient progress and therapist discretion:** Up to _____

☐ **Visits:** Frequency/Duration 1 2 3 4 5 x/week for _____ weeks Up to _____ visits

**Treatment Goals:**

☐ + ROM ☐ + Strength ☐ - Pain ☐ - Swelling ☐ + Flexibility ☐ Restore Function ☐ Desensitization

### Procedures

- ☐ Range of Motion PROM AROM AAROM
- ☐ Edema Control
- ☐ Joint Mobilization
- ☐ Manual Therapy TFM MFR STM
- ☐ Tool Assisted STM (Graston)
- ☐ Neuromuscular RE-Education
- ☐ Scar Management

### Exercise Programs

- ☐ Back Rehabilitation/Neck Rehabilitation
- ☐ Shoulder Rehabilitation
- ☐ Elbow Rehabilitation
- ☐ Wrist/Hand Rehabilitation
- ☐ Knee Rehabilitation
- ☐ Ankle Rehabilitation
- ☐ Gait Training
- ☐ Strengthening/Conditioning
- ☐ Home Exercise
- ☐ Posture/Body Mechanics Training
- ☐ Pre-Op Exercise

### Modalities

- ☐ As Indicated
- ☐ Ultrasound
- ☐ Phonophoresis (10% Hydrocortisone)
- ☐ Traction
- ☐ Electrical Stim (TENS IFC EGS FES)
- ☐ Iontophoresis (Dexamethasone 4mg/ml)
- ☐ Strengthening
- ☐ Fluidotherapy
- ☐ Paraffin

### Splint/Orthosis

- ☐ Describe _____
- ☐ Dynamic ☐ Static
- ☐ Elbow ☐ Forearm/Wrist ☐ Hand

### Specialty Programs

- ☐ Dancers ☐ Runners ☐ Throwers
- ☐ Spinecare ☐ Golf Fitness

## PROVIDER INFORMATION

Date: _____ /_____ /_____ Referring Provider Name: _____

Referring Provider Signature: _____ UPIN / NPI:_____

Phone: (____) _____-_____ Fax: (____) _____-_____