**Name**______________________________________________

**Diagnosis**__________________________________________

**ICD-9 Code**________________________________________

☐ **Evaluate and Treat for Physical Therapy**

**Frequency/Duration**_________________________________

**Specialty Programs/Instructions:**

- ☐ Weight Bearing Status
  - ☐ WBAT
  - ☐ PWB
  - ☐ NWB
- ☐ RTC Protocol
  **size of tear**______________
- ☐ McKenzie Spine Program
- ☐ Kinesiotaping
- ☐ TENS application & setup
- ☐ Modalities:
  - ☐ as needed
  - ☐ cryotherapy
  - ☐ moist heat
  - ☐ ultrasound
  - ☐ iontophoresis
  - ☐ electrical stimulation
- ☐ Range of Motion
  - ☐ PROM
  - ☐ AAROM
  - ☐ AROM
- ☐ Bankhart Protocol
- ☐ ACL Protocol
- ☐ Patellofemoral Taping
- ☐ Home Exercise Program
- ☐ Laser Light therapy
- ☐ Gait/Balance Training
- ☐ Hand Therapy

☐ Other ______________________________________________

**Physician Signature**_____________________________**Date**_________