PHYSICAL THERAPY / OCCUPATIONAL THERAPY REFERRAL

PATIENT NAME: _____ TODAY'S DATE: _____ _____ _____
Month Day Year

DIAGNOSIS: Internal derangement

PRECAUTIONS/CONTRAINDICATIONS: _____

Weight bearing:

FREQUENCY ☐2) ☐3 ☐(4) X A WEEK _____ WEEK/S _____ NWB _____ FWB _____ PWBAT

_____EVAULATE AND TREAT

GOALS: _X_ ↓ PAIN _X_ ↑ ROM _X_ ↑ STRENGTH _X_ ↓ SWELLING _X_ IMPROVE FUNCTION

MODALITITES

_X_ US
_X_ TENS
_____ PARAFFIN BATH
_X_ MOIST HEAT
_____ ICE
_____ ELECTRICAL STIM
_____ TRACTION _____LBS
_____ INTERFERENTIAL
_____ AT THE THERAPIST'S DISCRETION

MANUAL THERAPIES

_____ GENTLE MASSAGE
_____ MYOFACIAL RELEASE
_____ JOINT MOBILIZATION
_____ ISOMETRIC STABILIZATION
_____ CERVICAL
_____ LUMBAR
_____ STRETCHING

EXERCISES

Active
_____ ROM
_____ ISOMETRICS
_____ MCKENZIE EXTENSION EXERCISE
_____ BIOMECHANICS TRAINING
_____ BAPS/BALANCE EXERCISE
_____ STRENGTHENING EXERCISES
_____ THERAPEUTIC EXERCISE
_____ GAIT TRAINING/AMBULATION
_____ MET (MUSCLE ENERGY TECHIQUES)
_____ FLEXIBILITY EXERCISE
_____ MET (MUSCLE ENERGY TECHIQUES)
_____ STRETCHING (FUNCTIONAL)
_____ HOME EXERCISE PROGRAM
_____ POSTURAL CORRECTION EXERCISE
_____ WILLIAMS FLEXION EXERCISE
_____ PNF
_____ PROPRIOCIPTION TRAINING EXERCISES
_____ ENDURANCE EXERCISE
_____ PLYOMITRICS

SPECIFIC INSTRUCTIONS: _____

PHYSICIAN'S SIGNATURE: _____ _____ ,M.D.