



SOUTH LAKE LAND
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Patient Name _____ Phone # _____
 Diagnosis _____ Date of Onset _____
 Procedure _____ Date of Surgery _____
 Precautions _____

EVALUATE AND TREAT

Duration: _____ Weeks **Frequency:** 1 2 3 4 5 Days/Week _____ **Visits**

Objectives

- Decrease Pain Spasm Functional Skills
- Improve Range of Motion Gait Balance
- Strength Flexibility

Modalities

- At Therapist's Discretion
- Electrotherapy
- Ultrasound
- Electrical Stimulation
- TENS
- Iontophoresis

Procedures

- Robotic Therapy
- Myofascial Release
- Neuromuscular Re-education
- Manual mobilization

- Therapeutic Exercise
- Flexibility
- Coordination
- Strengthening
- Functional Training
- Gait Training
- ADL
- Balance Training
- AlterG/Antigravity Treadmill
- Functional Capacity Evaluation (FCE)
- Other: _____

- Hot Packs
- Cold Packs
- Photo / Laser

- Traction
- Cervical
- Lumbar
- ROM
- Passive
- Active Assist
- Active

Verbal Order received from: _____ Date _____

Therapist's Signature: _____ Print Name _____

I certify that the rehabilitation services outlined in the plan of care are necessary to the treatment of the condition and required by the patient. While under my care the plan of care established will be reviewed every thirty days or more often if the condition warrants.

Physician's Signature: _____ Date: _____

Please Print Name: _____

Thank you for giving us the opportunity to serve you & your patients

