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- Physical Therapy
 Occupational Therapy

14440 N Lincoln Blvd,
 Edmond, OK 73013
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Therapy services exceeding your expectations.

DEREK MICHAEL, PT, COS-C
CHRIS STRAIN, PT
JENNIFER FITZPATRICK, MOT, OTR/L

| | | | |
|---------------------|--------|-----------|-------|
| Patient Name: | | | |
| Patient Phone: | | | |
| DOB: | | | |
| Dx: | | | |
| Surgical Procedure: | | | |
| Precautions: | | | |
| Frequency: | x/week | Duration: | weeks |



Outpatient Clinic Located at
 14440 N Lincoln Blvd, Edmond, OK 73013
 (between Santa Fe Ave. & North Kelley Ave.)

Evaluate and Treat Home Exercise Program

Physician Specific Instructions:

| Exercise: | Therapeutic Activities: | Manual Therapy: | Programs: | Modalities: |
|---|--|---|--|---|
| <input type="checkbox"/> Passive ROM | <input type="checkbox"/> Body Mechanics | <input type="checkbox"/> Joint Mobilization | <input type="checkbox"/> Work Activities | <input type="checkbox"/> TENS Application |
| <input type="checkbox"/> Active Assist ROM | <input type="checkbox"/> Gait Training | <input type="checkbox"/> Soft Tissue Mob. | <input type="checkbox"/> Sports Activities | <input type="checkbox"/> Heat/Ice |
| <input type="checkbox"/> Active ROM | <input type="checkbox"/> ADL Activities | <input type="checkbox"/> Manual Stretching | <input type="checkbox"/> Back School | <input type="checkbox"/> US/Phono |
| <input type="checkbox"/> Resisted ROM | <input type="checkbox"/> Neuromuscular Re-ed | <input type="checkbox"/> Manipulation | <input type="checkbox"/> Ergonomic Assess | <input type="checkbox"/> Electrical Stim |
| <input type="checkbox"/> Functional Stability | <input type="checkbox"/> Balance | <input type="checkbox"/> McConnell Taping | <input type="checkbox"/> FCE | <input type="checkbox"/> Traction |
| <input type="checkbox"/> Isometrics | <input type="checkbox"/> Core Training | <input type="checkbox"/> Kinesiotaping | <input type="checkbox"/> Vestibular Rehab | <input type="checkbox"/> Iontophoresis |
| <input type="checkbox"/> Progressive Restive | <input type="checkbox"/> Desensitization | | <input type="checkbox"/> Splinting | <input type="checkbox"/> Fluidotherapy |
| <input type="checkbox"/> Tendon/Nerve glides | | | <input type="checkbox"/> Wrist/Hand Rehab | |

Follow Up Appointment with Physician:

My signature below certifies that the therapy services for the above named patient are required, medically necessary and authorized by me.

Physician's Signature _____ Date _____