



# OLYMPIC SPORTS AND SPINE REHABILITATION REFERRAL FOR REHABILITATION

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Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Diagnosis/Chief Complaint: \_\_\_\_\_

ICD-9: \_\_\_\_\_

Precautions/Comments: \_\_\_\_\_

Date of Return Appointment with Physician: \_\_\_\_\_

**THERAPIST: Please evaluate and design a treatment program appropriate for the above diagnosis.**

Specific Requests: \_\_\_\_\_

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Physical Therapy      | <input type="checkbox"/> Body Mechanics/Postural Training | <input type="checkbox"/> Cx/Lx Stab Protocol   | <input type="checkbox"/> Aquatic Therapy |
| <input type="checkbox"/> Physical Conditioning | <input type="checkbox"/> Manual Therapy                   | <input type="checkbox"/> Home Exercise Program | <input type="checkbox"/> Massage Therapy |

### Hand/Upper Extremity Therapy (Located at the Puyallup and 40th St. University Place Clinics)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Range of Motion | <input type="checkbox"/> Splinting             | <input type="checkbox"/> Joint/Soft Tissue Mobilization |
| <input type="checkbox"/> Strengthening   | <input type="checkbox"/> Wound/Scar Management |   |

### Industrial Rehabilitation (Located at the Puyallup and 40th St. University Place Clinics)

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Physical Capacity Evaluation | <input type="checkbox"/> Work Hardening                      | <input type="checkbox"/> On Site Ergonomic Assessment     |
| <input type="checkbox"/> Work Conditioning            | <input type="checkbox"/> Work Capacity/Simulation Evaluation | <input type="checkbox"/> Body Mechanics/Postural Training |

### TREATMENT PLAN:

Therapist Discretion

FREQUENCY:  PRN  5x/wk  3x/wk  2x/wk  1x/wk for \_\_\_\_\_ Weeks

PHYSICIAN SIGNATURE \_\_\_\_\_

**THANK YOU FOR YOUR REFERRAL. PLEASE SEE REVERSE SIDE FOR CLINIC LOCATIONS.**