Fax to: (425) 688-5710 Phone: (425) 688-5700

Please complete first section (required)

Patient name:______________________ Patient's gender: ☐ M ☐ F DOB: __________

Patient's contact number: (home)__________ (cell)__________ (work)__________

Reason For Exam: ______________________ or ICD9: __________

Physician name (please print): ______________________

Additional report to: ______________________

Physician's office contact: ______________ Phone: ______________

Physical/ Spine & Sport

- ☐ **Physical Therapist to evaluate and treat per therapist's judgment**
- ☐ **Vestibular Eval/ Tx**
- ☐ **Pelvic Floor Eval/ Tx**
  - ☐ **Biofeedback for pelvic floor disorders**
    - ☐ **Patient did not improve after 30 day trial of pelvic floor exercises (Required by Medicare)**
- ☐ **Pool Therapy**
- ☐ **Manual Therapy**
- ☐ **Ultrasound**
- ☐ **Electrical Stimulation**
- ☐ **TENS**
- ☐ **Passive Rom**
- ☐ **Active-Assistance ROM**
- ☐ **Progressive Resistive Exercise**
- ☐ **Aerobic Exercise/ Conditioning**
- ☐ **Gait/ Balance Training**
- ☐ **Traction**
  - ☐ Cervical ☐ Lumbar ☐ Manual ☐ Mechanical
- ☐ **Patient Education**
- ☐ **Home Exercise Program**
- ☐ **Posture and Body Mechanics**

Occupational

- ☐ **Occupational Therapist to evaluate and treat per therapist's judgment**
- ☐ **UE Eval/ Tx**
- ☐ **Hand Eval/ Tx**
- ☐ **Splinting (Specify below)**
- ☐ **Functional Electrical Stimulation**
- ☐ **ADL Eval/ Tx**
- ☐ **Driving Screen**
- ☐ **Home Safety Evaluation**
- ☐ **Worksite Ergonomic Assessment**

Speech

- ☐ **Speech Language Pathologist to evaluate and treat per therapist's judgment**
- ☐ **Speech/ Lang Eval/ Tx**
- ☐ **Cognitive Eval/ Tx**
- ☐ **Voice Eval/ Tx**
- ☐ **Swallowing Eval/ Tx**
- ☐ **Modified Barium Swallow**

Frequency

☐ Daily ☐ 3/ week ☐ 2/ week ☐ 1/ week ☐ For ______weeks

Special Instructions: ____

____

______________________ Physician Signature __________ Date __________ Time

P H Y S I C I A N O R D E R

OUTPATIENT REHABILITATION ORDERS

P0193C (Rev 0410)