



Patient: _____ Date: _____

Diagnosis: _____ DOB: _____

CENTRALIZED SCHEDULING LINE & FAX
phone 520-884-9819 fax 520-884-0175

EVALUATE & TREAT: Please Indicate Frequency: Daily 3x 2x for _____ weeks

FOLLOW POST-OP PROTOCOL:

TREATMENT GOALS:

- Decrease Pain Increase ROM Increase Strength & Function

PROGRAMS:

- Shoulder Core Stability Low Back Running
 Work Conditioning Balance Vestibular Strength

EXERCISE

- Stabilization
 McKenzie Method
 Home Program
 ROM Active
 ROM Passive
 Postural Training

MANUAL THERAPY

- Myofascial Release
 Joint Mobilization
 Trigger Point Massage
 Dry Needling*
**(Must be checked for permission of treatment)*

MODALITIES

- Hot Packs
 Ultrasound
 Ice
 Electrical Stimulation
 Traction
 Iontophoresis* Using:
 Dexamethasone
 Ketoprofen

GAIT TRAINING

- Full Weight Bearing
 PWB _____ %
 Non Weight Bearing
 Gait Analysis
 Fall Risk Assessment

PRECAUTIONS: _____

I authorize this treatment, which is medically necessary for the above named patient

Physician Signature: _____ Date: _____

Printed Name: _____

WEST TUCSON

1777 W. St. Mary's Rd
Tucson, AZ 85745

EAST CENTRAL TUCSON

6206 E. Pima, Suite 3
Tucson, AZ 85712

NORTH FOOTHILLS

1605 E. River Rd, Suite 201
Tucson, AZ, 85718

NORTHEAST TUCSON

8987 E. Tanque Verde, Suite 301
Tucson, AZ, 85749

SOUTHEAST TUCSON

7355 S. Houghton Rd, Suite 109
Tucson, AZ 85747

All services are available without distinction to all program participants regardless of race, color, national origin, handicap, age or sexual orientation.

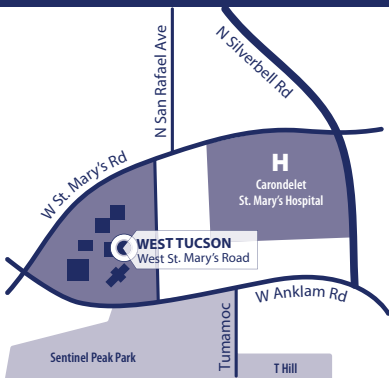


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www.agilitypt.com

WEST TUCSON



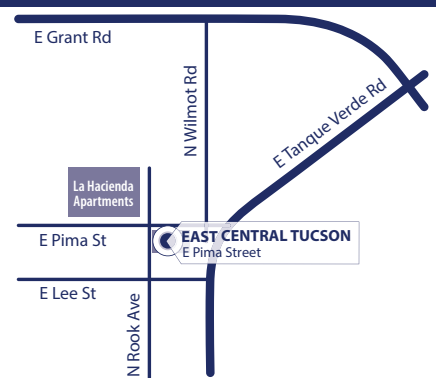
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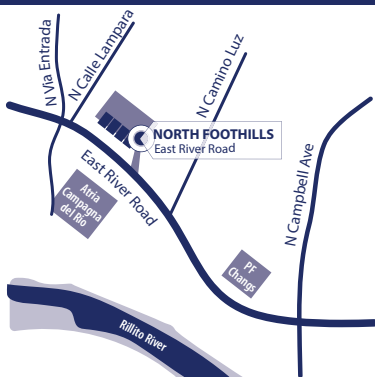
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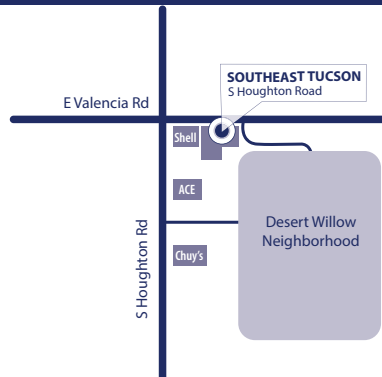
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