



Shady Oaks Plaza
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Medical Referral Form/Plan of Care: PLEASE PRINT

Patient: _____ Diagnosis: _____

DOI: _____ DOS: _____ Procedure: _____

Precautions / Special Instructions: _____

Objectives / Goals

- ____ Decrease pain
- ____ Decrease swelling
- ____ Improve range of motion
- ____ Improve strength
- ____ Improve conditioning
- ____ Improve functional skills
- ____ Patient education

Treatments

- ____ Evaluate and treat
- ____ Hot packs / cold packs
- ____ Ultrasound
- ____ Traction
- ____ Spine program
- ____ Kinetics / therapeutic exercise
- ____ Isokinetic exercise
- ____ Isokinetic testing

Other : _____

Frequency: _____ times per week

Duration: _____ weeks

Rehabilitation Potential: _____ Excellent _____ Good _____ Fair _____ Poor

Is patient aware of diagnosis and prognosis? _____ Yes _____ No

I certify that this rehabilitation treatment is medically necessary, the plan of care is established and will be reviewed every 30 days or more often if the condition warrants.

Physician's Signature: _____ Date: _____

Verbal Order _____ Date: _____ Signature: _____

____ Continue therapy