

CONTACT

PHYSICAL THERAPY

Name _____ Date _____

Patient Daytime Phone Number _____

Diagnosis/ICD 9 Code _____

Frequency of Treatment:

1 2 3 4 5 visits/week

Evaluate and Treat

Duration of Treatment:

1 2 3 4 weeks

Procedures:

- Therapeutic Exercise
- ROM: _____
- Trunk Stabilization
- Joint/Soft Tissue Mobs
- Desensitization
- Wound Care/Scar Care
- Neuromuscular Re-Ed
- Home Exercise Program
- Other: _____

Modalities:

- Ultrasound/Phonophoresis
- Electrical Stimulation
- Hot/Cold Therapy
- Iontophoresis
- Paraffin
- Fluidotherapy
- ASTYM
- Vestibular Rehab
- Whirlpool (Hand only)
- Other: _____

Hand Protocols (Scottsdale Location):

- Flexor Tendon-zone _____
- Extensor Tendon-zone _____
- CTS/Cubital Tunnel
- MCP/CMC Arthroplasty
- CPRS
- Tennis Elbow
- TOS
- Other: _____
- Splint Fabrication:** Static / Dynamic
Hand Based or Forearm Based

Instruction _____

Physician Name (Printed): _____ **Date:** _____

Physician Signature: _____

Locations in Mesa and Scottsdale

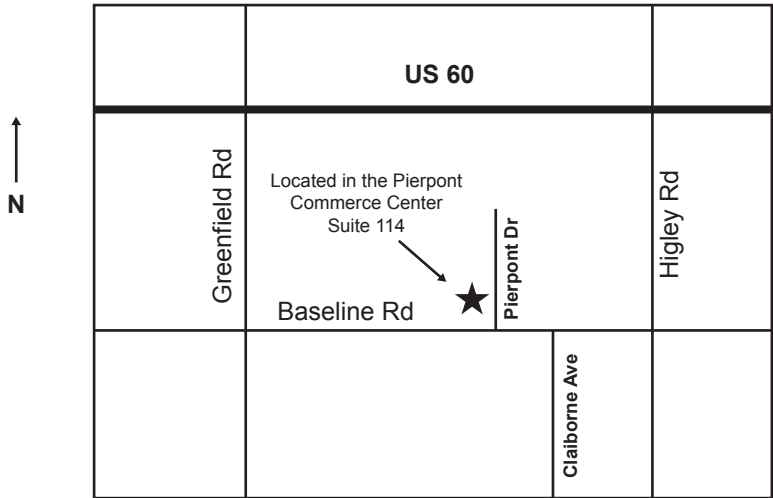
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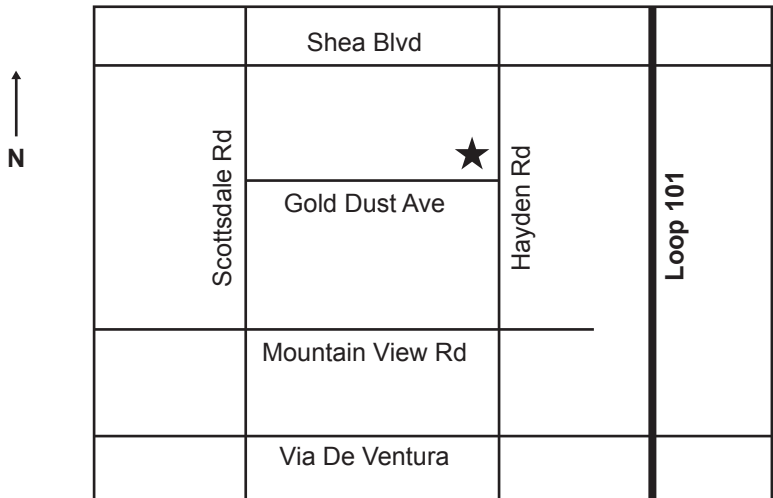
Mesa Location

4850 E. Baseline Rd., Suite 114, Mesa, AZ 85206
 (P) 480.396.2781 • (F) 480.854.3094



Scottsdale Location

10304 N. Hayden Rd., Suite 8, Scottsdale, AZ 85258
 (P) 480.429.5266 • (F) 480.429.5297



Karen A. Thomas, OTR/L, CHT and Brendan P. Cousineau, PT, CSCS