Saltzer HEALTH

Physical Therapy Order Form

875 S Vanguard Way STE 110
Ph: 208.960.0930
Fax: 208.960.0935
PT@Saltzerhealth.com

Patient Information

*Patient Name: ______________________ *Patient DOB: ______________________

*Patient Phone: ______________________

*Diagnosis: ☐ Right ☐ Left ☐ Bilateral ______________________

Request for Physical Therapy

☐ Evaluate & Treat
☐ 1-2 Visit for HEP Instruction
☐ Return to Sport Testing
☐ Fall Prevention

☐ Occupational Health/Work Comp
Claim #: ______________________
☐ MVA/Accident
Claim #: ______________________

☐ Post Operative Protocol
****Date of Surgery:*** ______________________
****Procedure(s) Performed:*** ______________________
Special Considerations: ______________________

☐ Precautions:

Weight Bearing
☐ WBAT
☐ NWB x ________
☐ TTWB/FFWB x ________
☐ PWB ____ % x ________

Then…
☐ Progress ___% every ___weeks
☐ Progress as tolerated

Sling Wear
☐ 23 hours/day x ________
☐ Abd pillow x ________
☐ Wean @ ________

☐ ***ADDITIONAL PRECAUTIONS***: ______________________

Treatment

☐ Functional Training/ADLs
☐ Balance Training
☐ Return to Sport Program
☐ Return to Work Program
☐ Injury Prevention
☐ Ergonomic Training/Education

☐ Range of Motion
☐ Joint Mobility
☐ Stability
☐ Strengthening
☐ Proprioceptive Control
☐ Gait Training

☐ Concussion
☐ Tendinosis
☐ Chronic Pain Education
☐ Pre-Operative Care
☐ Home Program

Frequency & Duration:
☐ Per Therapist Discretion/Plan of Care
____Visits per ☐ week ☐ month for ____ ☐ weeks ☐ months

____
Referring Provider (Please Print Legibly)

☐ MD ☐ NP ☐ DDS
☐ DO ☐ DNP ☐ DPM
☐ PA-C ☐ DMD ☐ Other: ________

____
Signature

____
Date