Patient ______________________ Phone # ______________________

Diagnosis/Procedure ______________________

______________________

______________________

ICD-10 Codes ______________________

Date of Patient's next appointment ______________________

**Instructions:** ☐ Evaluate & Treat    Report by: ☐ Phone ☐ Letter ☐ Fax

**Modalities:**
- ☐ As Indicated
- ☐ Electrical Stim
- ☐ Heat/ cold
- ☐ Ultrasound
- ☐ Phonophoresis
- ☐ Iontophoresis

**Procedures:**
- ☐ Mobilization/ Manual Therapy
- ☐ Therapeutic Exercise
- ☐ Passive/Active
- ☐ Isotonic
- ☐ Isometric
- ☐ Range of Motion
- ☐ Home Program (HEP)
- ☐ Gait Training
- ☐ Strengthening
- ☐ Therapeutic Massage
- ☐ Carpal Tunnel Therapy
- ☐ Hand Therapy
- ☐ Aerobic Conditioning
- ☐ Proprioception/Coordination
- ☐ Balance Re-Training/Vestibular Rehab.
- ☐ Back School Program
- ☐ Back/pelvic Stabilization
- ☐ **Functional Capacity Evaluation**
- ☐ **Traction**
  - ☐ Cervical
  - ☐ Lumbar
  - ☐ Wrist
- ☐ Work Rehabilitation
- ☐ Work Conditioning

**Treatment Plan:** ☐ Therapist's Discretion

Frequency / Duration    1 2 3 4 5 Times Per Week for _____ Weeks

Additional Comments/ Instructions ______________________

______________________

______________________

______________________

Physician's Signature: ______________________ Date: __________

*Thank You for this referral!*

6701 W. Blondell Dr. Wasilla, AK 99654 Phone: 907-357-9755 Fax: 907-357-9499
www.firstchoiceak.com