

Tim Bondy Physical Therapy

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| <input type="checkbox"/> 1333 Spring Street | (231) 487-4638, fax 231-487-4615 |
| <input type="checkbox"/> 1171 W. Conway Road | (231) 487-6163, fax 231-347-0567 |
| <input type="checkbox"/> 930 State St., #10 | (231) 242-0791, fax 231-242-0913 |
| <input type="checkbox"/> Home Rehabilitation Specialists | (231) 347-6636, fax 231-347-2886 |

Physical Therapy **Occupational Therapy** **Home Care**

Patient Name	Frequency/Duration of Treatment																								
Diagnosis	ICD-9																								
Precautions (if any)																									
<input type="checkbox"/> Evaluate and Treat <input type="checkbox"/> Other/Special Instructions <hr style="border: 0; border-top: 1px solid black; margin: 5px 0;"/> <hr style="border: 0; border-top: 1px solid black; margin: 5px 0;"/>																									
<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top; padding: 2px;"><input type="checkbox"/> Ultrasound</td> <td style="width: 50%; vertical-align: top; padding: 2px;"><input type="checkbox"/> Postural Instruction</td> </tr> <tr> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Phono / Iontophoresis</td> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Back School</td> </tr> <tr> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Hydrocollater Pack</td> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Independent Functional Evaluation</td> </tr> <tr> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Hot / Cold Pack</td> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Work-Safe Preparation Program</td> </tr> <tr> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Electrical Stimulation</td> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Orthotics</td> </tr> <tr> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Orthopaedic Manual Therapy</td> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> ADL Evaluation</td> </tr> <tr> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Manual Traction</td> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Paraffin Bath</td> </tr> <tr> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Massage</td> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Splinting / Adaptive Equipment</td> </tr> <tr> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Exercise Strengthening</td> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Sensory / Safety Awareness</td> </tr> <tr> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Exercise ROM / Stretching</td> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Hand Dexterity</td> </tr> <tr> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Gait Training</td> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Home Program Instruction</td> <td></td> </tr> </table>		<input type="checkbox"/> Ultrasound	<input type="checkbox"/> Postural Instruction	<input type="checkbox"/> Phono / Iontophoresis	<input type="checkbox"/> Back School	<input type="checkbox"/> Hydrocollater Pack	<input type="checkbox"/> Independent Functional Evaluation	<input type="checkbox"/> Hot / Cold Pack	<input type="checkbox"/> Work-Safe Preparation Program	<input type="checkbox"/> Electrical Stimulation	<input type="checkbox"/> Orthotics	<input type="checkbox"/> Orthopaedic Manual Therapy	<input type="checkbox"/> ADL Evaluation	<input type="checkbox"/> Manual Traction	<input type="checkbox"/> Paraffin Bath	<input type="checkbox"/> Massage	<input type="checkbox"/> Splinting / Adaptive Equipment	<input type="checkbox"/> Exercise Strengthening	<input type="checkbox"/> Sensory / Safety Awareness	<input type="checkbox"/> Exercise ROM / Stretching	<input type="checkbox"/> Hand Dexterity	<input type="checkbox"/> Gait Training	<input type="checkbox"/> Other _____	<input type="checkbox"/> Home Program Instruction	
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Physician Signature	Date																								
Physician's Typed Name:																									
<p>Follow up and progress reports will be sent to the referring physician to communicate findings, test results, and progress of the patient. Any desired changes in treatment will be requested from the referring physician.</p>																									