



Change Starts Here

Occupational / Physical Therapy Order to Evaluate and Treat

Patient Name _____ DOB _____ Phone _____

Diagnosis Code(s) _____

_____ times per week for _____ weeks _____ as needed (PRN) (optional information below)

FEMALE
(Pelvic Floor Programs)

MALE
(Pelvic Floor Programs)

ORTHOPEDIC REHAB

- ___ Pelvic Floor Strengthening
___ Pelvic Relaxation
___ Pelvic Pain
___ Bladder Retraining
___ Overactive Bladder
___ Bowel Re-Education
___ Internal Manual Therapy
___ Manual Therapy
___ Postural Ed/Body Mechanics
___ Core Strengthening
___ Sexual Dysfunction
___ Prenatal/Post-Partum Program
___ Diastasis Re-Education
___ Home Exercise Program

- ___ Pelvic Floor Strengthening
___ Pelvic Relaxation
___ Pelvic Pain
___ Bladder Retraining
___ Overactive Bladder
___ Bowel Re-Education
___ Internal Manual Therapy
___ Manual Therapy
___ Postural Ed/Body Mechanics
___ Core Strengthening
___ Sexual Dysfunction
___ Home Exercise Program

- ___ Postural Education
___ Body Mechanics
___ General Conditioning
___ Balance Retraining
___ Myofascial Release
___ Soft Tissue Mobilization
___ Home Exercise Program

Additional Instructions/Restrictions/Precautions _____

PROVIDER SIGNATURE _____ DATE _____

In making this referral, the provider certifies that the prescribed treatment is medically necessary

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