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**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 MALE ORTHOPEDIC REHAB**

*(Pelvic Floor Programs)*  *(Pelvic Floor Programs)*

\_\_\_Pelvic Floor Strengthening \_\_\_Pelvic Floor Strengthening \_\_\_Postural Education

\_\_\_Pelvic Relaxation \_\_\_Pelvic Relaxation \_\_\_Body Mechanics

\_\_\_Pelvic Pain \_\_\_Pelvic Pain \_\_\_General Conditioning

\_\_\_Bladder Retraining \_\_\_Bladder Retraining \_\_\_Balance Retraining

\_\_\_Overactive Bladder \_\_\_Overactive Bladder \_\_\_Myofascial Release

\_\_\_Bowel Re-Education \_\_\_Bowel Re-Education \_\_\_Soft Tissue Mobilization

\_\_\_Internal Manual Therapy \_\_\_Internal Manual Therapy \_\_\_Home Exercise Program

\_\_\_Manual Therapy \_\_\_Manual Therapy

\_\_\_Postural Ed/Body Mechanics \_\_\_Postural Ed/Body Mechanics

\_\_\_Core Strengthening \_\_\_Core Strengthening

\_\_\_Sexual Dysfunction \_\_\_Sexual Dysfunction

\_\_\_Prenatal/Post-Partum Program \_\_\_Home Exercise Program

\_\_\_Diastasis Re-Education

\_\_\_Home Exercise Program

**Additional Instructions/Restrictions/Precautions**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**PRINTED NAME OF PROVIDER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PROVIDER SIGNATURE** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

4920 E State St. Suite 4 Rockford IL 61108(ph)**815.637.1100** (fx)**815.637.1200**

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