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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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