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)

- ___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

MALE
(Pelvic Floor Programs)

- ___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

ORTHOPEDIC REHAB

- ___Postural Education
- ___Body Mechanics
- ___General Conditioning
- ___Balance Retraining
- ___Myofascial Release
- ___Soft Tissue Mobilization
- ___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

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