SHEPARD THERAPY CENTER

Dr. Sean Shepard, PT, DPT, OT/L

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Patient's Name: _____ Date of Birth: ___/___/___
Physician's Name: _____ Follow-up Date: ___/___/___
Diagnosis: _____
Patient can be reached for an appointment at: PH# _____

This order is for: ☐ **Physical Therapy** ☐ **Occupational Therapy**

Frequency of Treatment: _____ x per week for _____ weeks

Evaluate and treat at therapist's discretion ☐

Check specific modalities and treatments if desired:

☐ **Modalities**
- ☐ Laser
- ☐ Ultrasound
- ☐ Electrical Stimulation
- ☐ Iontophoresis
- ☐ Traction
- ☐ Heat/Cold

☐ **Exercises**
- ☐ Strength/Endurance Training
- ☐ Stabilization Program (Cerv, Thor, Lumb)
- ☐ AROM
- ☐ AAROM
- ☐ Home Program
- ☐ Functional Training

☐ **Sport Specific Rehabilitation & Training**
- ☐ Sport: _____

☐ **Manual Therapy**
- ☐ Joint Mobilization
- ☐ Spinal Mobilization
- ☐ Soft Tissue Mobilization
- ☐ PROM
- ☐ Scar Massage

☐ **Vestibular Rehabilitation**
- ☐ BPPV
- ☐ Balance Training

☐ **Gait Training**
- ☐ Orthotic Fit/Training
- ☐ Alter G
- ☐ Weight Bearing Instructions
  ____ % unweighting

☐ **Other/Precautions:** _____

I hereby certify that this Physical/Occupational Therapy is medically necessary for this patient's wellness.

_____ _____
Physician's Signature Today's Date

THANK YOU FOR YOUR REFERRAL! **PLEASE FAX THIS FORM TO 912-632-6322**