



HTS OUTPATIENT THERAPY  
 PRESTWICK POINTE  
 5250 E US HWY 36, Ste. 670  
 Avon, Indiana 46123  
 phone: 317-745-9908 fax: 317-745-7255

Office Hours:  
 7am-7pm Monday-Thursday, 8am-5pm Friday  
*Additional hours available if necessary*

(Map located on back)

Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Diagnosis \_\_\_\_\_ DOB: \_\_\_\_\_

Precautions: \_\_\_\_\_

Freq/Duration: \_\_\_\_\_  As Indicated by Therapist

PT

OT

ST

### PHYSICIANS ORDERS:

- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Evaluate and Treat</li> <li><input type="checkbox"/> Therapeutic Exercise           <ul style="list-style-type: none"> <li>Strengthening</li> <li>PROM/AROM</li> <li>Endurance</li> </ul> </li> <li><input type="checkbox"/> Home Exercise Program</li> <li><input type="checkbox"/> Manual Therapy           <ul style="list-style-type: none"> <li>Joint Mobilization</li> <li>ASTM/CFM</li> <li>Myofascial Release</li> <li>Muscle Energy Technique</li> </ul> </li> <li><input type="checkbox"/> Lumbar Stabilization</li> <li><input type="checkbox"/> Traction (Cervical/Lumbar)</li> <li><input type="checkbox"/> Gait Training</li> <li><input type="checkbox"/> Proprioception/Balance</li> <li><input type="checkbox"/> FCE: Functional Cap. Eval</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Edema Mgmt.           <ul style="list-style-type: none"> <li>Intermittent Compression Pump</li> <li>Compression Garment Fitting</li> <li>Lymphedema Massage</li> </ul> </li> <li><input type="checkbox"/> Orthotics (custom foot orthotics)</li> <li><input type="checkbox"/> OT: Custom Hand Splinting</li> <li><input type="checkbox"/> TENS Unit Fitting</li> <li><input type="checkbox"/> Modalities as indicated           <ul style="list-style-type: none"> <li>___ Iontophoresis_w/ Dex</li> <li>___ Ultrasound/Phonophoresis</li> <li>___ Electrical Stimulation</li> <li>___ Moist Heat/Cryotherapy</li> <li>___ Paraffin Bath</li> <li>___ Anodyne Therapy</li> </ul> </li> <li><input type="checkbox"/> Other: _____</li> <li>_____</li> <li>_____</li> </ul> |
|--|---|

I certify this treatment program as medically necessary.

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_