



THIBODEAU PHYSICAL THERAPY

ORTHOPAEDICS & SPORTS MEDICINE

Dave Thibodeau PT, Owner

www.thibodeaupt.com

Patient Name: _____

Diagnosis: _____

Frequency: _____ per week for _____ weeks

■ EVALUATE AND TREAT

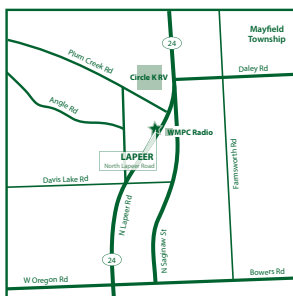
- | | |
|--|---|
| <input type="checkbox"/> Therapeutic Exercise | <input type="checkbox"/> Splinting |
| <input type="checkbox"/> Strengthening | <input type="checkbox"/> Fluidotherapy |
| <input type="checkbox"/> Gait Training <input type="checkbox"/> Full <input type="checkbox"/> Partial <input type="checkbox"/> Non | <input type="checkbox"/> Paraffin Bath |
| <input type="checkbox"/> Non Weight Bearing | <input type="checkbox"/> Ultrasound |
| <input type="checkbox"/> Neuro Muscular Re-Education | <input type="checkbox"/> Phonophoresis - 10% Hydrocortisone |
| <input type="checkbox"/> Joint Mobilization | <input type="checkbox"/> Iontophoresis - Dexamethasone |
| <input type="checkbox"/> Soft Tissue Mobilization | <input type="checkbox"/> Electrical Stimulation |
| <input type="checkbox"/> Massage | <input type="checkbox"/> TENS |
| <input type="checkbox"/> Traction <input type="checkbox"/> Cervical <input type="checkbox"/> Lumbar | <input type="checkbox"/> Home program/ADL Training |
| <input type="checkbox"/> Whirlpool <input type="checkbox"/> Chlorzazine Additive | <input type="checkbox"/> Authorization for Alternate Procedures |

Remarks/Precautions: _____

I certify the above services are required by this patient on an outpatient basis.

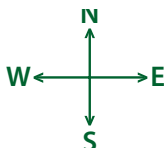
Signature: _____ Date: _____

DO NOT EMAIL PRESCRIPTION The electronic prescription form is provided for your convenience. With respect to responding to this form, please do not send the prescription via email. Please populate, print and sign a hardcopy that may be faxed, mailed or hand delivered to the clinic.



LAPEER

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