

LOCATIONS:

Danville
Ph: (317) 745-3420
Fx: (317) 745-8340
1000 E. Main St.

Avon – YMCA
Ph: (317) 272-4186
Fx: (317) 272-4190
301 Satori Parkway

Brownsburg – North
Ph: (317) 858-9400
Fx: (317) 858-9494
65 E. Garner Road,
Ste. 100

Plainfield
Ph: (317) 838-3434
Fx: (317) 838-3449
1100 Southfield Dr.,
Ste. 1100

Physical Therapy Occupational Therapy Aquatic Therapy (Plainfield only)

PATIENT'S NAME		DATE
DIAGNOSIS		
FREQUENCY <input type="checkbox"/> 1X/WK <input type="checkbox"/> 2X/WK <input type="checkbox"/> 3X/WK <input type="checkbox"/> 5X/WK <input type="checkbox"/> OTHER:		SURGERY DATE
DURATION <input type="checkbox"/> 3 WKS <input type="checkbox"/> 4 WKS <input type="checkbox"/> 6 WKS <input type="checkbox"/> OTHER:		<input type="checkbox"/> URGENT
GOALS <input type="checkbox"/> DECREASE PAIN / SWELLING <input type="checkbox"/> INCREASE STRENGTH AND / OR ENDURANCE <input type="checkbox"/> INCREASE ROM AND / OR FLEXIBILITY		

Treatment

<input type="checkbox"/> EVALUATE, DEVELOP & INITIATE PLAN OF CARE	<input type="checkbox"/> AQUATIC THERAPY	<input type="checkbox"/> PRE-OP EVALUATION
<input type="checkbox"/> FCE (FUNCTIONAL CAPACITY EVALUATION)	<input type="checkbox"/> ORTHOTICS	<input type="checkbox"/> JOB SITE/ERGO ANALYSIS
<input type="checkbox"/> INSTRUMENTAL LIGAMENT TEST (KT1000)	<input type="checkbox"/> WOUND MANAGEMENT	<input type="checkbox"/> VIDEO ANALYSIS

Modalities

<input type="checkbox"/> MODALITIES OF CHOICE	<input type="checkbox"/> CRYOTHERAPY & EDEMA CONTROL	<input type="checkbox"/> ELECTRICAL STIMULATION	<input type="checkbox"/> FLUIDOTHERAPY
<input type="checkbox"/> IONTOPHORESIS	<input type="checkbox"/> TRACTION (CERVICAL/LUMBAR)	<input type="checkbox"/> TENS	<input type="checkbox"/> ULTRASOUND

Exercises/Manual Therapy

<input type="checkbox"/> RANGE OF MOTION	<input type="checkbox"/> STRENGTHENING	<input type="checkbox"/> ISOMETRICS	<input type="checkbox"/> GAIT/ANALYSIS TRAINING
<input type="checkbox"/> PASSIVE	<input type="checkbox"/> STABILIZATION	<input type="checkbox"/> HEP	<input type="checkbox"/> CRUTCHES
<input type="checkbox"/> ACTIVE-ASSIST	<input type="checkbox"/> FLEXIBILITY	<input type="checkbox"/> SWISS BALL EXERCISES	<input type="checkbox"/> CANE WALKER
<input type="checkbox"/> ACTIVE	<input type="checkbox"/> LUMBAR STABILIZATION	<input type="checkbox"/> AQUATIC THERAPY	<input type="checkbox"/> NWB, 25%, 50%, 75%, FWB
<input type="checkbox"/> GENTLE	<input type="checkbox"/> TAPING	<input type="checkbox"/> ASTYM	<input type="checkbox"/> PROGRESS AT THERAPIST DISCRETION
<input type="checkbox"/> AGGRESSIVE	<input type="checkbox"/> JOINT MOBILIZATION	<input type="checkbox"/> OTHER: _____	

Protocols

<input type="checkbox"/> CAPSULAR SHIFT (REGULAR/ACCELERATED)	<input type="checkbox"/> LATERAL RELEASE	<input type="checkbox"/> TKA PROTOCOL
<input type="checkbox"/> MUMFORD, DECOMPRESSION	<input type="checkbox"/> ACL	<input type="checkbox"/> THA
<input type="checkbox"/> ROTATOR CUFF REPAIR (SMALL TO MEDIUM)	<input type="checkbox"/> HAMSTRING GRAFT	<input type="checkbox"/> ANTERIOR APPROACH
<input type="checkbox"/> ROTATOR CUFF REPAIR (LARGE TO MASSIVE)	<input type="checkbox"/> BTB GRAFT	<input type="checkbox"/> POSTERIOR APPROACH
<input type="checkbox"/> SLAP REPAIR	<input type="checkbox"/> MCL PROTOCOL	<input type="checkbox"/> TSA
<input type="checkbox"/> BICEPS TENODESIS	<input type="checkbox"/> MICROFRACTURE CHONDROPLASTY	<input type="checkbox"/> STANDARD
<input type="checkbox"/> MENISCUS REPAIR	<input type="checkbox"/> OATS PROCEDURE	<input type="checkbox"/> REVERSE
<input type="checkbox"/> BANKART REPAIR	<input type="checkbox"/> OTHER: _____	<input type="checkbox"/> PPP

Splint Evaluation and Fabrication

<input type="checkbox"/> CMC	<input type="checkbox"/> DORSAL BLOCK	<input type="checkbox"/> FINGER SPLINT	<input type="checkbox"/> LONG ARM	<input type="checkbox"/> RESTING PAN	<input type="checkbox"/> SAFE POSITION
<input type="checkbox"/> STATIC ELBOW	<input type="checkbox"/> THUMB SPICA	<input type="checkbox"/> ULNAR GUTTER	<input type="checkbox"/> WRIST COCK UP	<input type="checkbox"/> OTHER: _____	

Special instructions/precautions:

This recommended treatment is medically necessary to:

- | | |
|---|---|
| <input type="checkbox"/> PROMOTE FULL FUNCTIONING POST-OP | <input type="checkbox"/> PREVENT NEED FOR NON-CONSERVATIVE METHOD |
| <input type="checkbox"/> ACHIEVE ABOVE OBJECTIVE / GOALS | <input type="checkbox"/> OTHER: _____ |

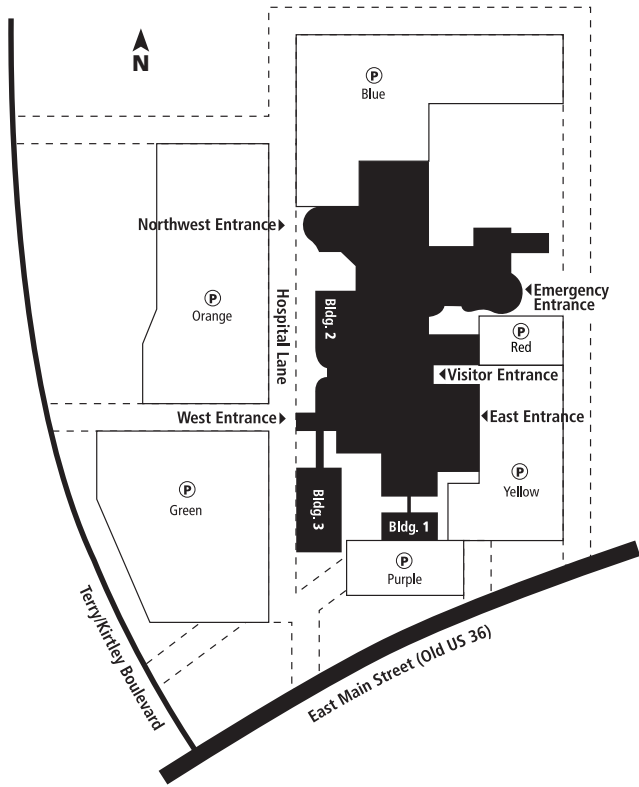
Physician Signature* _____ Date _____

*Signature indicates for evaluation by therapist to be completed and care initiated with formal plan of care to be signed by physician in timely fashion.

Hendricks Regional Health

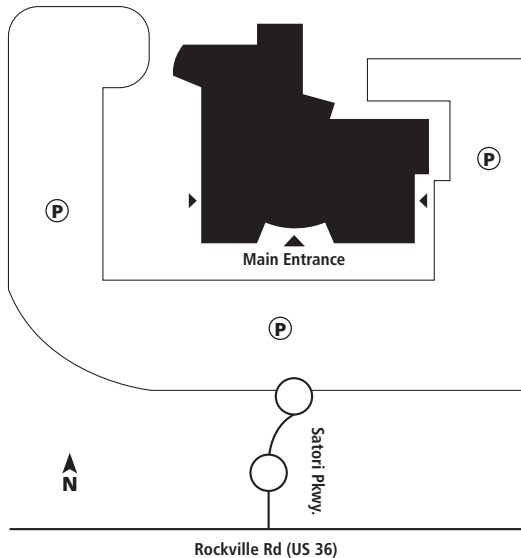
PT/OT/AT Service Locations

DANVILLE



Enter at West Entrance
 1000 East Main Street
 (317) 745-3420

AVON – YMCA



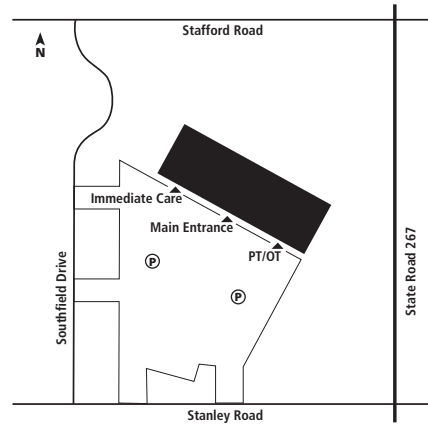
Enter at Main Entrance
 301 Satori Parkway
 (317) 272-4186

BROWNSBURG – NORTH



65 E. Garner Road, Ste. 100
 (317) 858-9400

PLAINFIELD



Enter at PT/OT Entrance
 1100 Southfield Drive
 (317) 838-3434