PLAN OF CARE

Aquatic, Rehab & Sports Clinic

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Patient: ___________________________________ Date:__________

Treatment Diagnosis______________________ PT___ OT___ST___

Area to be Treated: ____

Long Term Goals ____

Frequency of visits ______________________ Per week for:___ weeks

Physicians Recheck on: _____________________________________

☐ EVALUATION and TREATMENT AS NECESSARY

AQUATIC THERAPIES

- ☐ ROM
- ☐ Strength
- ☐ Plyometrics

MODALITIES

- ☐ Hot Moist Packs
- ☐ Ultrasound
- ☐ Light Therapy
- ☐ Electrical Stimulation
- ☐ Ice Pack with Intermittent Compression
- ☐ Ice Massage
- ☐ Ice Pack
- ☐ Soft Tissue Release/Art
- ☐ Electrical Muscle Stimulation
- ☐ Contrast Baths
- ☐ Joint Mobilization
- ☐ Hiva-mat 200 w/deep oscillation

STATIC/INTERMITTENT TRACTION

- ☐ Cervical
- ☐ Pelvic

EXERCISE

- ☐ Passive
- ☐ Active
- ☐ Active Assistive
- ☐ Prog. Resistance Ex.
- ☐ Back/Core Stability Ex.
- ☐ Home Program
- ☐ Balance Training
- ☐ Sport Specific Exer. _______________
- ☐ Gait Training W/______________________________
- ☐ Non-Wt. Bearing
- ☐ Wt. Bearing As Tol.

☐ PAIN MANAGEMENT PROGRAM

HAND REHABILITATION

- ☐ Active ROM
- ☐ Active Assistive ROM
- ☐ Passive ROM
- ☐ Strengthening
- ☐ Manual Dexterity
- ☐ Static
- ☐ Dynamic
- ☐ Edema Reduction
- ☐ Hand Protocol
- ☐ Sensory Re-education
- ☐ Scar Management
- ☐ Isometric Exercise
- ☐ Carpal Tunnel Syndrome

☐ SOCIAL OR VOCATIONAL SERVICES

Precautions/Special Instructions ____

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* PHYSICIAN'S SIGNATURE

* I hereby certify this plan of care is medically necessary.