

VANCOUVER SPINE & ORTHOPEDIC REHABILITATION CENTER, PLLC

*Formerly Orchards Physical Therapy*

11802 NE 65th St.  
Vancouver, WA 98662  
(360) 253-6883  
(360) 892-7040 fax

Patient Name: \_\_\_\_\_ Diagnosis: \_\_\_\_\_ Date: \_\_\_\_\_

PHYSICAL THERAPY

EVALUATE & TREAT

PROCEDURES

FREQUENCY (circle) 5x 4x 3x 1x per week

- \_\_\_\_ LORDEX Lumbar Decompression
- \_\_\_\_ Hand Rehab – Carpal Tunnel Program
- \_\_\_\_ Shoulder Rehab Program
- \_\_\_\_ Spinal Rehab Program
- \_\_\_\_ Knee Rehab Program
- \_\_\_\_ Ankle Rehab Program
- \_\_\_\_ Strength Testing – Treatment
- \_\_\_\_ Electro Diagnostic Testing
- \_\_\_\_ Joint Mobilization
- \_\_\_\_ Progressive – Resistive Exercises
- \_\_\_\_ Range of Motion Exercises
- \_\_\_\_ Isometric Exercises
- \_\_\_\_ Gait – Transfer Training
- \_\_\_\_ Conditioning – Fitness Program
- \_\_\_\_ Home Exercise Program
- \_\_\_\_ TMJ Program
- \_\_\_\_ Balance Training

DURATION (circle) 1 2 3 4 6 8 week(s)

PRECAUTIONS: \_\_\_\_\_

SPECIAL INSTRUCTIONS: \_\_\_\_\_

X-RAY FINDINGS: \_\_\_\_\_

I certify that the above treatment program is medically necessary.

Signed: \_\_\_\_\_ Date \_\_\_\_\_

Print Doctor Name: \_\_\_\_\_

Clinic Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

VANCOUVER SPINE & ORTHOPEDIC REHABILITATION CENTER, PLLC

*Formerly Orchards Physical Therapy*

11802 NE 65th St.  
Vancouver, WA 98662  
(360) 253-6883  
(360) 892-7040 fax

Patient Name: \_\_\_\_\_ Diagnosis: \_\_\_\_\_ Date: \_\_\_\_\_

PHYSICAL THERAPY

EVALUATE & TREAT

PROCEDURES

FREQUENCY (circle) 5x 4x 3x 1x per week

- \_\_\_\_ LORDEX Lumbar Decompression
- \_\_\_\_ Hand Rehab – Carpal Tunnel Program
- \_\_\_\_ Shoulder Rehab Program
- \_\_\_\_ Spinal Rehab Program
- \_\_\_\_ Knee Rehab Program
- \_\_\_\_ Ankle Rehab Program
- \_\_\_\_ Strength Testing – Treatment
- \_\_\_\_ Electro Diagnostic Testing
- \_\_\_\_ Joint Mobilization
- \_\_\_\_ Progressive – Resistive Exercises
- \_\_\_\_ Range of Motion Exercises
- \_\_\_\_ Isometric Exercises
- \_\_\_\_ Gait – Transfer Training
- \_\_\_\_ Conditioning – Fitness Program
- \_\_\_\_ Home Exercise Program
- \_\_\_\_ TMJ Program
- \_\_\_\_ Balance Training

DURATION (circle) 1 2 3 4 6 8 week(s)

PRECAUTIONS: \_\_\_\_\_

SPECIAL INSTRUCTIONS: \_\_\_\_\_

X-RAY FINDINGS: \_\_\_\_\_

I certify that the above treatment program is medically necessary.

Signed: \_\_\_\_\_ Date \_\_\_\_\_

Print Doctor Name: \_\_\_\_\_

Clinic Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_