Therapy Appointment Reminder

Indiana University Health Arnett Orthopedics & Sports Medicine

APPOINTMENT

Date: ________________________

Time: _______________ AM PM

Please arrive 15 minutes prior to your appointment.

Please bring your insurance card and co-pay with you to all appointments. We appreciate a cancellation notice at least 24 hours in advance, if you cannot keep your appointment. A cancellation message can be taken 24-hours a day at 765.448.8600.

LOCATION

☐ 2600 Ferry Street, Lafayette
☐ 5177 McCarty Lane, Lafayette
T 765.448.8200
F 765.448.7670

☐ Occupational Therapy/Athletic Training ☐ Physical Therapy/Athletic Training

Please be sure to contact your insurance company if precertification is necessary for therapy services.

Patient Name: ____ Pt. History #: ______________

Diagnosis: ____

ICD-10 Code: ____

Precautions: ____

Date of Onset/Surgery: ____

Treatment Frequency: ___________ x/wk ____________ wks Therapist discretion: ______________________

TREATMENT

☐ Evaluate and Treat
☐ Home Program Only 1-2 visits
☐ Eval & Tens Unit
☐ Tens Unit Only
☐ WB
☐ Heat Modalities/Cryotherapy
☐ Iontophoresis
☐ ACL Protocol
☐ Home Cervical Traction
☐ Traction
☐ Manual Therapy
☐ Stretching/Flexibility
☐ Biodex Isokinetic Test
☐ Electrical Stimulation
☐ Patellofemoral Protocol
☐ McKenzie Spine Evaluation
☐ Ultrasound/Phonophoresis
☐ ROM (act) (pass)
☐ Strengthen/Conditioning
☐ Gait Training
☐ Back Care Education
☐ Desensitization/Scar Mgmt
☐ Myofascial Protocol
☐ Other: ______________________

TREATMENT OBJECTIVES/GOALS

☐ Correct Postural Defects
☐ Improve Body Mechanics
☐ Improve Understanding
☐ Increase Endurance
☐ Manage Pain
☐ Manage Swelling
☐ Increase ROM/Mobility
☐ Other: ____________________________
☐ Improve Coordination
☐ Improve General Fitness
☐ Increase Strength

Notes: ____

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Physician's Signature: ____________________________________ Date: ________________________

Arnett Physicians

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