MINNEAPOLIS
ORTHOPAEDICS
Advanced skills and experience for the results you deserve

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(612) 333-5000 Fax:(612) 333-6922

PHYSICAL THERAPY ORDER

Patient's Name: _____

Patient's Diagnosis: _____

_____

Contraindications: _____

_____

Significant Past Medical History: _____

_____

Physician's Order: _____

_____

SPECIFIC TREATMENT REQUESTED

_____ Evaluate and Treat
_____ Hot Packs
_____ Cold Packs
_____ Ultrasound
_____ Whirlpool
_____ Electrical Stimulation
_____ Traction
_____ Massage
_____ Gait Training
_____ Contrast
_____ Diathermy
_____ Cybex Test
_____ Strengthening Exercises
_____ Flexibility Exercises
_____ ROM Exercises
_____ TENS
_____ Muscle Re-education

Frequency and Duration of Treatment: _____

_____

_____

_____ _____
Physician's signature *Physical Therapist's signature*

_____ _____
Date *Date*