



AQUATIC HEALTH AND REHABILITATION SERVICES, INC.

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REFERRAL / CARE PLAN

Patient's Name: _____		Phone #: _____
Diagnosis: _____	Physician: _____	
Date of Onset / Surgery: _____	Type of Surgery / Date: _____	

Area To Be Treated: _____ Precautions / Limitations: _____

PHYSICAL THERAPY

EVALUATE AND TREAT

- Cold / Hot Pack
- Electrical Stimulation
- Ultrasound
- Traction
- Mobilization - Massage
- TENS
- Iontophoresis / Phonophoresis
- Aquatic Therapy
- Edema Reduction
- Kinetic Exercise / ROM
 - Passive Active PRE
 - Bodymaster Biodex Aerobics
- Isokinetic Extremity Test
- Gait Training
 - NWB PWB FWB
- Foot & Ankle Rehabilitation
- Orthotics Permanent / Temporary
- Custom Foot
- Pediatric Program
- McKenzie Approach
- Golf Program
- Biofeedback
- Other _____

OCCUPATIONAL THERAPY

EVALUATE AND TREAT

- Hand & Upper Extremity Rehabilitation
- Kinetic Exercise / ROM
- Mobilization
- Massage / Desensitization
- ADL Training
- Functional Activities
- Cold / Hot Pack
- NMES / TENS
- Splinting
 - Static Dynamic
- Paraffin
- Ultrasound
- Sensory Re-education
- Strengthening Exercise
- Joint Protection Instruction
- Scar Management
- Biofeedback
- Other _____

COMPREHENSIVE THERAPY

- Comprehensive Spine Program**
- Functional Capacity Evaluation
- Physical Reconditioning

SPEECH THERAPY

- EVALUATE AND TREAT**
- Swallowing Program
- Voice / Communication Program
- Cognitive Rehab
- Memory Program
- Aphasia Program
- Pediatric Program
- Aquatic Therapy
- Other _____

RESTORATION POTENTIAL: Excellent Good Fair Limited

GOAL & TARGET DATE:

- Pain Management _____ Increase ROM _____ to _____
- Independent in Functional Activities / ADLS _____ Increase Strength _____ to _____
- Return To Work / Community _____ Promote Healing / Prevent Infection _____
- Control Edema / Swelling _____ Scar Management Anesesisitization _____
- Proper Posture & Body Mechanics _____ Other _____

Frequency _____ x week for _____ weeks.

My signature authorizes this treatment to be medically necessary. As part of my client's treatment, I further authorize AQUATIC HEALTH AND REHABILITATION SERVICES, INC. to use education / biofeedback as part of the treatment plan as needed.

Physician's Signature: _____ Date of Referral: _____

Therapist Signature: _____ Date: _____

Patient: _____ Date: _____

The above has been explained to me.