

**COLUMBUS
OT, CHT**
2369 Beam Road
Columbus, IN 47203
T: (812) 378-4182
F: (812) 378-4194



**SEYMOUR
PT, OT, CHT**
1171 W. Tipton St., Ste L
Seymour, IN 47274
T: (812) 522-7007
F: (812) 522-7043

www.therapyworksseymour.com
Laura Barker, OTR, CHT, Clinic Director

<input type="checkbox"/> Occupational/Hand Therapy <i>(Upper Extremity: Shoulder to Hand)</i>	<input type="checkbox"/> Physical Therapy
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Name: _____ DOB: _____

Phone Number: _____

Diagnosis: _____

Frequency: _____

EVALUATE & TREAT

- | | |
|---|---|
| <input type="checkbox"/> Wound Care | <input type="checkbox"/> Scar Care |
| <input type="checkbox"/> Splinting: _____ | <input type="checkbox"/> Gel Sleeve |
| <input type="checkbox"/> Modalities | <input type="checkbox"/> Elastomer |
| <input type="checkbox"/> Whirlpool | <input type="checkbox"/> Supplies |
| <input type="checkbox"/> Ultrasound/Phonophoresis | <input type="checkbox"/> Putty |
| <input type="checkbox"/> Iontophoresis | <input type="checkbox"/> Hand Helper |
| <input type="checkbox"/> TENS | <input type="checkbox"/> Theraband |
| <input type="checkbox"/> Paraffin | <input type="checkbox"/> Pullies |
| <input type="checkbox"/> Estim | <input type="checkbox"/> Aircast/Armband |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> AV Glove |
| <input type="checkbox"/> ROM | <input type="checkbox"/> Other: |
| <input type="checkbox"/> AAROM | <input type="checkbox"/> Home Exercise Program |
| <input type="checkbox"/> AROM | <input type="checkbox"/> Myofascial Techniques |
| <input type="checkbox"/> PROM | <input type="checkbox"/> Soft Tissue Mobilization |
| <input type="checkbox"/> Strengthening | <input type="checkbox"/> Job Site Analysis |
| <input type="checkbox"/> Joint Mobilization | <input type="checkbox"/> Fuctional Capacity Evaluations |
| <input type="checkbox"/> Desensitization/ Sensory Re-Ed | <input type="checkbox"/> Work Conditioning |
| <input type="checkbox"/> Edema Control | |
| <input type="checkbox"/> Isotoner Glove | |
| <input type="checkbox"/> Stockinette | |

Special Instructions/Precautions: _____

I hereby certify that the above listed physical therapy modalities and procedures are medically necessary for treatment of this patient's diagnosis and condition.

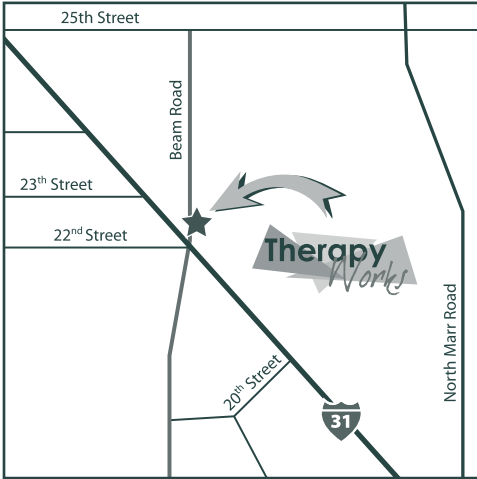
Signature: _____ Date: _____

DO NOT EMAIL PRESCRIPTION The electronic prescription form is provided for your convenience. With respect to responding to this form, please do not send the prescription via email. Please populate, print and sign a hardcopy that may be faxed, mailed or hand delivered to the clinic.



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COLUMBUS - PT, OT, CHT

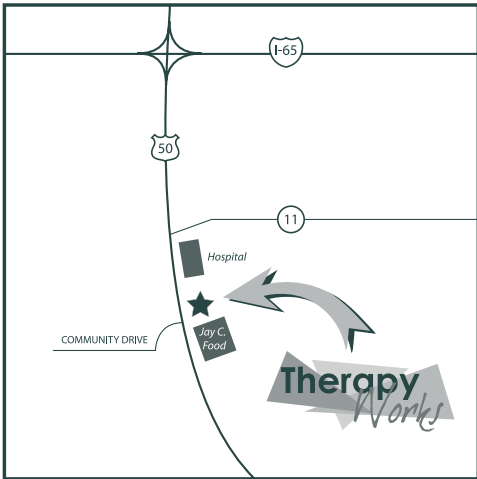
Located directly behind Subway/Snappy

Tomato in **Clover Center** area

2369 Beam Road

Columbus, IN 47203

Tel. 812-378-4182 | Fax 812-378-4194



SEYMOUR - PT, OT, CHT

TherapyWorks is located at Tipton

Crossing next to the Jay C Food Store in

Seymour on west end of town.

1171 West Tipton Street, Suite L

Seymour, IN 47274

Tel. 812-522-7007 | Fax 812-522-7043

JUST A REMINDER:

Please bring this referral slip with you on your first visit.

Please arrive 15 minutes before your scheduled appointment to complete the necessary paperwork.

Evaluations (1st visit) usually last 1 hour.