5 Elements
Pelvic Health & Women's Physical Therapy

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Patient Name: _____ Phone: _____

DOB: _____ Date of onset: _____

Physician: _____ Physician phone: _____

Diagnosis/ICD10: _____

Precautions: _____

Other: _____

PHYSICAL THERAPY TREATMENT

____Evaluate and treat ____Therapeutic Exercise ____Manual therapy

____Home program ____Biofeedback/e-stim ____Neuromuscular Re-education

____ Therapeutic activities

Other _____

TREATMENT GOALS

Improve: ____Function ____ROM ____Strength

Independence with home program: ____

Other: _____

Duration/Frequency: ____as per therapist ____times a week per week for ____weeks.

Thank you for referring this patient to 5 Elements Pelvic Health and Women's Physical Therapy.

If you have any questions or concerns, please feel welcome to contact me at:

805-316-4344 or annfrost.pt@gmail.com.

Physician Signature: _____ Date: _____

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