Destination Life
Therapy and Wellness

Name: ____ Phone: ________________________

❑ **Occupational Therapy**

MODALITIES

___ Electric Stimulation

___ T.E.N.S

___ Heat/Cold

___Traction (Cervical/Back)

___ Ultrasound/Phonophoresis

SPECIALIZED PROGRAMS

___ AMPUTEE REHAB PROGRAM

___ COGNITIVE THERAPY

___ DIABETES Management

___ BALANCE TRAINING

___ HAND REHAB

___ INCONTINENCE THERAPY PROG.

___ OTHER: ___________________________

PROCEDURES

___ BACK SCHOOL

___ BALANCE/ PROPRIOCEPTION

___ FUNCTIONAL CAPACITY EVAL.

___ Functional Ambulation

___ HOME PROGRAM

___ JOINT MOBILIZATION

___ JOINT PROTECTION TRAIN

___ ONCOLOGY

___ OSTEOPOROSIS PROGRAM

___ PRENATAL BACK CARE

___ PULMONARY OCCUPATIONAL THERAPY

___ ROT. CUFF REPAIR PROTOCOL

___ SPORTS SPECIFIC CONDITIONING

___ VESTIBULAR REHAB

FREQUENCY: 1 2 3 4 5 /WK

DURATION FOR: ______ Weeks

____

M.D. SIGNATURE

Date: __________________

☐ EVALUATE & TREAT

DIAGNOSIS ____

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