



Date : _____

Request from Attending Physician for Physiotherapy

Patient's name: _____

To be filled by Attending Physician:

Diagnosis: _____

Physical findings and functional limitation: _____

List of ancillary tests if applicable: _____

Expected rate of improvement after physiotherapy: _____

Number of prescribed sessions: _____ Time span of therapy: _____

Suggested treatment modalities and number of sessions:

- | | | | |
|--------------------------|------------------------------------|----------------------------|-----------------------|
| 1 Traction | 8 Active assisted ROM | 14 Gait training | 20 Joint mobilization |
| 2 Electrical stimulation | 9 Active resisted ROM | 15 Ankle platform | 21 Contrast bath |
| 3 Vasopneumonic device | 10 Ultrasound | 16 Bicycle | 22 Infrared |
| 4 Paraffin bath | 11 Isometric therapeutic exercises | 17 Proprioceptive training | 23 Massage |
| 5 Diathermy | 12 Isotonic therapeutic exercises | 18 Posture training | 24 Stretching |
| 6 Active ROM | 13 Hydrotherapy | 19 Respiratory training | 25 Cold packs |
| 7 Passive ROM | | | 26 Hot packs |

N.B. Please enclose results of diagnostic tests or X-rays performed if applicable

Doctor's signature and stamp: _____

Telephone no. _____

To be filled by Physiotherapist:

Individual Number: _____

Contract Number: _____

	<u>Date of session</u>	<u>Modalities of treatment</u>	<u>Patient's signature</u>
I	____/____/____	_____	_____
II	____/____/____	_____	_____
III	____/____/____	_____	_____
IV	____/____/____	_____	_____
V	____/____/____	_____	_____
VI	____/____/____	_____	_____
VII	____/____/____	_____	_____
VIII	____/____/____	_____	_____
IX	____/____/____	_____	_____
X	____/____/____	_____	_____
XI	____/____/____	_____	_____
XII	____/____/____	_____	_____

Physiotherapist's signature and stamp: _____

Telephone no. _____

Number of Sessions Approved: _____

Approved by: _____

RM/MO's signature and stamp: _____