SCHREIBER UPPER EXTREMITY REHAB CLINIC
1500 Brook Avenue
Wichita Falls, TX 76301
Phone: 940-766-1515 Fax: 940-766-1539
www.SchreiberRehabClinic.com

NAME: ________________________________ PHONE: ______________________

DIAGNOSIS__________________________ SURGERY ______________________________

PRECAUTIONS_______________________ DATE OF INJURY__________NEXT DR. APPT______

Frequency of Rx/Week (circle): 1 2 3 4 5 Duration of Rx program (Circle): 1 2 3 4 5 WKS

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EVALUATE & TREAT______ EXERCISE PROTOCOL______ CONTINUE TREATMENT______

Special Programs

____ Arthritis Program
____ Functional ADL's
____ Job Site Assessment
____ Work Simulation Exercises
____ Lymphedema Program
____ Garments (Specify)
____
____
____

Modalities

____ Traction
____ Electrical Muscle Stimulation
____ Fluidotherapy
____ Hot packs/Cryotherapy
____ Iontophoresis
____ Paraffin
____ TENS/Home
____ Ultrasound/Phonophoresis
____ Whirlpool

Procedures

____ 1x Home Program
____ Passive/Active ROM
____ Isometrics
____ Joint Mobilization
____ Myofascial Release
____ Therapeutic Exercises
____ Wound Care
____ Splinting (Specify)
____
____

MONTH	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

I certify that I have reviewed this plan of care and therapy is medically necessary and required by the patient. Treatment will be furnished while the patient is under my care. This established plan will be reviewed every 30 days or as the patient's condition requires.

Signed: ____ Dated: ______________________
(Referring Physician)