

Patient Name _____ Phone _____

Diagnosis/ICD – 10 Code _____

Special Orders or Precautions _____

Non-Weight Bearing Toe Touch Partial Weight Bearing Full Weight Bearing

Evaluate and Treat

Treatment Guidelines

- PROM**
Start Date: _____
- AAROM**
Start Date: _____
- AROM**
Start Date: _____
- Strength**
Start Date: _____

Hand Therapy

- Desensitization
- Coordination
- Scar Mobilization
- Custom Splinting

Worker Rehab

- Work Conditioning
- Work Fitness

Specialty Services

- Lymphedema Therapy**
(Beaverton and Gresham)
- Blood Flow Restriction Training**
(Beaverton, Clackamas, NE Portland)
- Spinal Manipulation**
- Balance/Vertigo Therapy**
- AlterG Anti-Gravity Treadmill**
(Gresham)
- Pelvic Floor Physical Therapy**
(Gresham)
- BikeFit**
(NE Portland)
- Temporomandibular Joint (TMJ)**
- Fibromyalgia**
- Mechanical Spinal Traction**
- Pool Therapy**
(Sandy)

SportsCare

- Beaverton – Joe Shannon, DPT**
16100 NW Cornell Rd. Suite 110
Beaverton, OR 97006
P: 971.245.6663
F: 971.245.6664
- Clackamas – Ethan Collier, DPT**
10121 SE Sunnyside Rd. Ste 208
Clackamas, OR 97015
P: 503.794.0103
F: 503.794.0104
- Gresham – George Eischen, PT**
24076 SE Stark St. Ste. 200
Gresham, OR 97030
P: 503.491.1666
F: 503.491.1667
- NE Portland – Joe Fricke, PT**
10748 NE Halsey St.
Portland, OR 97220
P: 503.257.9881
F: 503.257.8964
- Sandy – Kevin Eischen, DPT**
16621 Champion Way Ste. 100
Sandy, OR 97055
P: 503.668.5321
F: 503.668.9742

Armworks

- Beaverton**
15390 NW Cornell Rd. Suite 230
Beaverton, OR 97006
P: 971.245.6663
F: 971.245.6664
- Clackamas**
10121 SE Sunnyside Rd. Ste 208
Clackamas, OR 97015
P: 503.794.0103
F: 503.794.0104
- Gresham**
24076 SE Stark St. Ste. 210
Gresham, OR 97030
P: 503.491.1666
F: 503.491.1667
- Lake Oswego**
16016 Boones Ferry Rd. Ste. 101
Lake Oswego, OR 97035
P: 503.882.2351
F: 503.882.2348
- NE Portland**
10748 NE Halsey St.
Portland, OR 97220
P: 503.257.9881
F: 503.257.8964

Frequency Daily 3x Wk 2x Wk 1x Wk Other _____

Duration 1 Week 2 Weeks 3 Weeks 4 Weeks Other _____

Physician Signature _____ Date _____

Physician Name _____ Phone _____