NEW REHABILITATION SERVICES

Carla J. Hedtke, BS, M.S., B.C.T.P.M
5765 KZ Lane – Oconto Falls, WI 54154
920-373-5002 (Fax) 920-846-3267

PRESCRIPTION/REFERRAL

Patient Name____ Date____________________

A. Diagnosis

(Include ICD-10 codes that specifically address Manual Therapy Treatment)

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____
____

Condition is related to

☐ Auto Accident
☐ Work Injury
☐ Illness
☐ Other __________________

B. Medically Necessary Treatment: Implement Plan as Prescribed Below

Application (Direct & Indirect)

☐ Head_______________________________
☐ Neck_______________________________
☐ Chest______________________________
☐ Shoulders___________________________
☐ Abdomen___________________________
☐ Back_______________________________
☐ Lowback/Hips______________________
☐ Upper extremities___________________
☐ Lower Extremities__________________
☐ All of the above: ___________________
☐ Other______________________________

Duration & Frequency

☐ 1 X wk for _______wks
☐ 2 X wk for________wks
☐ 3 X wk for________wks
☐ 2 X month for________months
☐ 1 X month for________months

Treatment Type

☐ Manual Therapy_____________________
☐ Hydrotherapy ________________________
☐ Self-Care Education__________________
☐ Other_______________________________

Treatment Goals

☐ Decrease Pain
☐ Decrease Inflammation
☐ Decrease Muscle Tension/Spasms
☐ Decrease Compensatory Patterns
☐ Increase Mobility
☐ Restore Function
☐ Restore Posture
☐ Maintain Associated Structures
☐ All of the Above
☐ Other_______________________________

Specific Instructions: ____
____
____
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C. Referring Health Care Provider (HCP)

Contact Information

HCP Name____________________________
Address_______________________________
City________________ State____ Zip______
Phone________________________________
Fax__________________________________
e-mail Address _________________________

Reporting

☐ Send Report After Initial Visit
☐ Send Report at End of Prescription
☐ Send Copies of Chart Notes at End of Prescription
☐ Fax Information
☐ Mail Information
☐ e-mail Information

HCP Signature: ____ Date______________

Please Mail to address listed below or fax to (920) 840-3267.

CarlaJ Hedtke, BS, M.S., B.C.T.P.M
5765 KZ Lane – Oconto Falls, WI 54154
920-846-3267 800-840-3267
tpmyotherapy@gmail.com www.tpmyotherapy.com