



JARRETT ORTHOPAEDIC REHABILITATION, INC.

2651 Irvine Avenue, Suite 128, Costa Mesa, CA 92627

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Name \_\_\_\_\_

Diagnosis \_\_\_\_\_

ICD-9# \_\_\_\_\_ Date of Surgery \_\_\_\_\_ (Please Send Operative Report)

Precautions \_\_\_\_\_

Frequency \_\_\_\_\_ Times Per Week

Duration \_\_\_\_\_ Weeks

**Procedures**

- Evaluation & Treatment
- Myofascial Release
- Therapeutic Exercise
- Neuro Re-Education
- Functional Training
- Aquatic Therapy
- Body Mechanics Training
- Gait Training
- Soft Tissue Mobilization
- Joint Mobilization
- Traction
- Orthotic

**Modalities**

- Electrical Stimulation
- Cryotherapy
- EMG
- Iontophoresis
- Phonophoresis
- Ultrasound

**Special Programs**

- Yoga-Flexibility Program
- Return To Running
- Return To Activity \_\_\_\_\_
- Videotape Analysis

**Rehabilitation Programs**

- |   |                                      |                              |
|---|--------------------------------------|------------------------------|
| <input type="checkbox"/> Shoulder                             | <input type="checkbox"/> Hip         | <input type="checkbox"/> C/S |
| <input type="checkbox"/> Elbow                                | <input type="checkbox"/> Knee        | <input type="checkbox"/> T/S |
| <input type="checkbox"/> Wrist/Hand                           | <input type="checkbox"/> Foot/Ankle  | <input type="checkbox"/> L/S |
| <input type="checkbox"/> General Musculoskeletal Conditioning | <input type="checkbox"/> Other _____ |                              |

Comments \_\_\_\_\_

\_\_\_\_\_

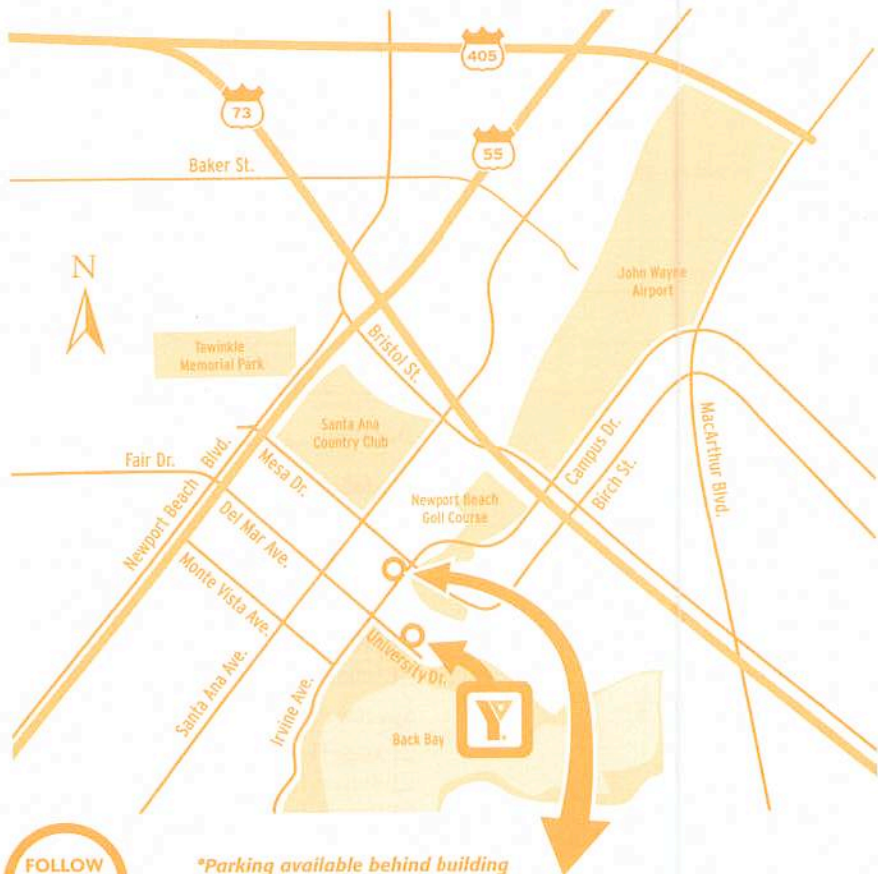
Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician's Name \_\_\_\_\_

Phone \_\_\_\_\_

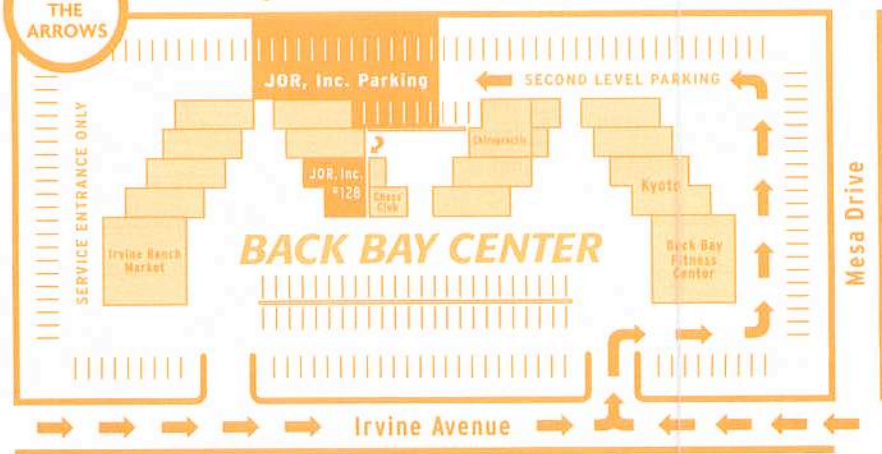
\*Patient is Responsible for Verifying Benefits with Insurance Company





**FOLLOW THE ARROWS**

*\*Parking available behind building*



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