empassion ELVIC HEALTH

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114 E Unaka Ave
Johnson City, TN 37601

Patient Name: _____ DOB: _____ Phone: _____

Referring Diagnoses: _____

PT/OT PRESCRIPTION

Pelvic Muscle Dysfunction

☐ Muscle Spasm	M62.838
☐ Muscle Weakness	M62.81
☐ Muscle Wasting	N81.84
☐ Lack of Coordination	R27.8

Ortho/Neuro

☐ Low Back Pain	M54.5
☐ Thoracic Pain	M54.6
☐ Coccydynia	M53.3
☐ Sciatica	M54.3
☐ Hip/Groin Pain	M25.559
☐ SI Dysfunction	M53.3
☐ Ehlers-Danlos Syndrome	Q79.6

Please indicate:

☐ Prenatal ☐ In Chemotherapy
☐ Post Partum ☐ In Radiation
☐ Falls Risk ☐ Osteoporosis/Osteopenia
☐ Infection ☐ _____

Pelvic Pain

☐ Pelvic & Perineal Pain	R10.2
☐ Endometriosis	N80.9
☐ Interstitial Cystitis	N30.10
☐ Painful Scar Adhesion	L90.5
☐ Chronic Prostatitis	N41.1
☐ Vaginismus	N94.2
☐ Vulvodynia	N94.819
☐ Pudendal Neuralgia	G58.9
☐ Dysmenorrhea	N94.6
☐ Dyspareunia	N94.1

Prolapse & Diastasis

☐ Cystocele	N81.10
☐ Rectocele	N81.6
☐ Diastasis Recti	M62.00
☐ Uterine Prolapse	N81.4

Urinary Conditions

☐ Stress Incontinence	N39.3
☐ Urge Incontinence	N39.41
☐ Mixed Incontinence	N39.46
☐ Nocturia	R35.1
☐ Urinary Urgency	R39.15
☐ Incomplete Emptying	R39.14
☐ Urinary Frequency	R35.0
☐ Overactive Bladder	N32.8

GI & Bowel Conditions

☐ Constipation	K59.02
☐ Abdominal Pain	R10.30
☐ Fecal Incontinence	R15.9
☐ Fecal Urgency	R15.2
☐ Irritable Bowel Syndrome (IBS)	K58.9

PT/OT PLAN OF CARE

☐ **Initial Care Plan**: Evaluate and treat per therapist discretion 1 to 2 times per week for up to 16 weeks.
☐ **Continued Care Plan**: Pt is making good progress, but is still presenting with dysfunction that warrants further care. Pt will be seen PRN 1-3x/month for the next 4 months to address continued issues to optimize quality of life and reduce symptoms.

Plan of Care: Treatment may include Therapeutic Exercises (ROM, strength, endurance, stability, recruitment), Neuromuscular Rehabilitation (muscle re-education, sequencing, coordination, PNF), Manual Therapy (soft tissue mobilization, myofascial release, joint mobilization, spinal mobilization, manual traction, muscle energy techniques, manual resistive exercise, visceral mobilization, strain/counter-strain, dry needling), Patient Education (home exercise program, ergonomics, posture, self-care techniques, activity modification), Modalities (to improve pain, decrease inflammation, increase blood flow and improve tissue healing) warm/hot packs

Certification of Medical Necessity: It will be understood that the treatment plan mentioned above is certified medically necessary by the documenting therapist and referring physician mentioned in this report. Unless the physician indicates otherwise through written correspondence with our office, all further referrals will act as certification of medical necessity on the treatment plan indicated above.

Special instructions or precautions: _____

Physician Signature: _____ Date: _____