empassion PELVIC HEALTH

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207 N Boone St, Ste 300
Johnson City, TN 37604

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
- ☐ Post Partum
- ☐ Falls Risk
- ☐ Infection
- ☐ In Chemotherapy
- ☐ In Radiation
- ☐ Osteoporosis/Osteopenia
- ☐ ______________

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: ______________