



ORTHOPAEDIC SPECIALISTS
of Northwest Indiana

730 - 45th Street, Munster, IN 46321

219-924-3300 • 219-922-5424 (fax)

www.osni.org

Rehabilitation Center

Date: _____

Patient Name: _____

Diagnosis: 0 hip OA

Evaluate and treat per therapist recommendation

Therapeutic Exercise

- Per therapist discretion
- Ankle rehabilitation
- Back rehabilitation
- Knee rehabilitation
- Shoulder rehabilitation
- Gait training
- General conditioning
- Home exercise instruction
- Isokinetics
- Passive range of motion
- Strengthening exercise
- Back education

Modalities

- Per therapist discretion
- Electrical stimulation
- Hot/cold packs
- Iontophoresis
- Traction
- Ultrasound
- Other _____

Hand Rehabilitation

- Per therapist discretion
- Exercise/ROM
- Specific protocol

Manual Therapy

- Joint mobilization
- Massage
- Soft tissue mobilization
- Stretching exercises

Additional instructions: Pre op teaching.

Surgery Date:

Frequency: Per therapist discretion

Specify _____ times per week for _____ weeks

From: _____/_____/_____ to _____/_____/_____

Physician certifies that the prescribed rehabilitation is medically necessary.

Referring Physician: Joseph D. Hecht, M.D.