



# BROKEN ARROW PHYSICAL THERAPY

ORTHOPEDIC, SPINE & HAND SPECIALIST

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**Todd Alpers, PT, OCS, CHT - Owner**

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_

Diagnosis \_\_\_\_\_

Frequency \_\_\_\_\_ Duration \_\_\_\_\_

### Programs

Orthostar<sup>sm</sup>  
Orthopedics &  
Sports Medicine

StraightUp<sup>sm</sup>  
Spinal Rehab

Back to Work  
Conditioning<sup>sm</sup>  
Industrial Rehab  
Program

PreOp 321<sup>sm</sup>  
Complimentary Pre-  
Op Visit

HandInHand<sup>sm</sup>  
Hand Rehab

Different Strokes<sup>sm</sup>  
Aquatic Rehab

### Evaluations

Evaluate and treat  
 Functional Capacity Evaluation  
 Other \_\_\_\_\_

### Modalities and Procedures

Electrical Stimulation  
 Ultrasound  
 Massage  
 Paraffin bath  
 Iontophoresis  
 Traction

Therapeutic exercise  
 Home exercise program  
 Joint mobilization  
 Patella strapping  
 Whirlpool  
 TENS  
 Wound care  
 Aquatic Therapy

Other \_\_\_\_\_  
\_\_\_\_\_

### Custom Splinting

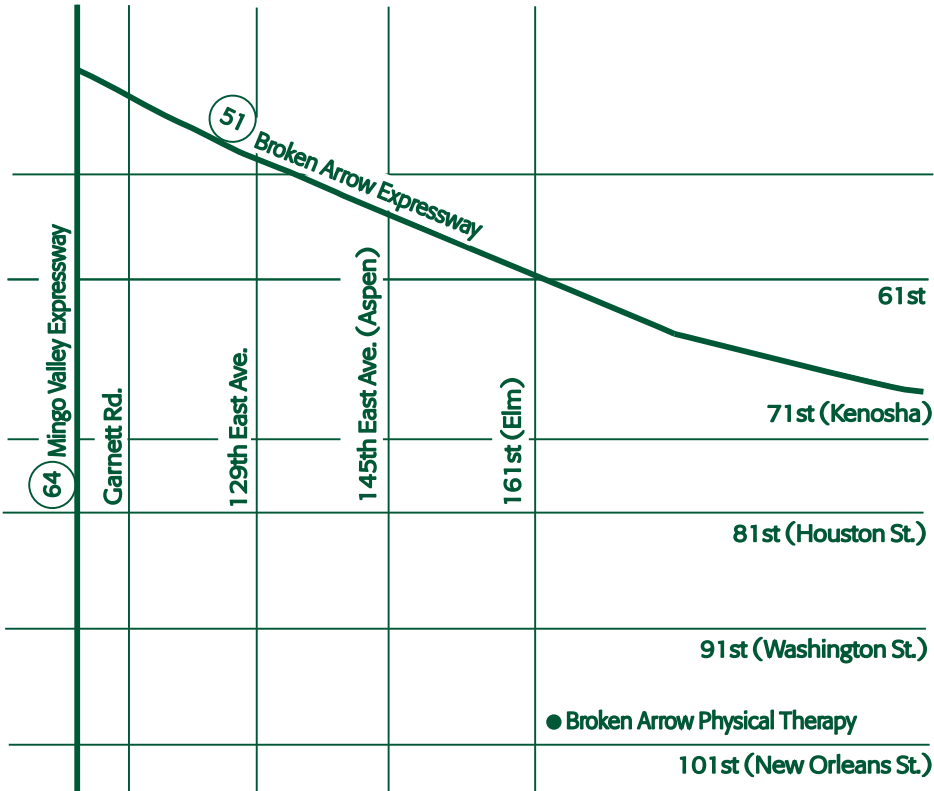
Dynamic  
 Static  
 Other \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

*I certify that I have examined the patient. The above stated treatment plan is necessary and will be provided while the patient is under my care.*

**DO NOT EMAIL PRESCRIPTION** The electronic prescription form is provided for your convenience. With respect to responding to this form, please do not send the prescription via email. Please populate, print and sign a hardcopy that may be faxed, mailed or hand delivered to the clinic.



● Broken Arrow Physical Therapy