REVO REHAB, INC.
Revolve. Revitalize. Revolutionize.

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Revo Rehab RX Form

Name: _____ **Date:** _____

Diagnosis: _____ **ICD-10**

Surgical Procedure: _____

Recommended TX Areas: _____

Contraindications: _____

# of Treatments: _____ **Frequency:** _____Times a Week, for _____ Weeks

Type of Therapy: (Check all that apply)

____ Evaluate & Treat
____ Cognitive Skill Development
____ Dysphagia Treatment (Speech)
____ Dysphagia Treatment (Swallowing)
____ Gait Training
____ Kinesiotaping/Splinting
____ Lymphedema Treatment
____ Manual Therapy
____ Modalities (E-Stim, Ultrasound, Heat/Ice)
____ Myofascial Release
____ Neck/Back School
____ Orthopedic Rehab (Pre/Post Surgery)
____ Pain Management
____ Physical
____ Prosthetic Training
____ ROM/Strengthening
____ Self-Care Training
____ Speech
____ Stabilization Exercises (Balance/fall prevention)
____ Stroke/Neuro Rehab
____ Therapist's Discretion
____ Urinary Incontinence
____ Vestibular Balance
____ Vital-Stim
____ Work Hardening

Other: _____

_____

_____

_____ _____

As Written - M.D. Signature Substitution Permitted - M.D. Signature