**16615 Lark Ave. Suites 101 & 105 • Los Gatos, CA 95032**
**PH: (408) 358-1460 FX: (408) 358-1459**
**Websites: www.lgost.com & www.kidsperspectivept.com**

***Orthopedic & Sports Therapy Group***
Ross Nakaji, PT, OCS, SCS, ATC, CSCS
Kevin McClenahan, DPT, OCS
Lianna Roberts, DPT, OCS
Lori Leonard, MPT, CEAS
Chase Perez, DPT, CSCS
An Truong, DPT
John Barr, DPT, ATC

***Los Gatos Hand Therapy***
Laurann Putnam, OTR, CEAS, CMT

***Pediatric Therapy Group***
Kristine Nakaji, MPT, PCS
Rebecca Wong, DPT
An Truong, DPT

***Vestibular/Dizzy/Concussion Rehab***
Lianna Roberts, DPT, OCS

***Ergonomics/Workstation Assessment***
Laurann Putnam, OTR, CEAS, CMT
Lori Leonard, MPT, CEAS

**Patient's Name**______________________________________________________

**Diagnosis**__________________________________________________________

**Comments/Precautions**________________________________________________

- **Evaluate and Treat**
  Biomechanical evaluation, ROM measurements, strength testing, flexibility, neurological screening, manual therapy, patient education and home exercise program

| | | |
|---|---|---|
| ACL/CKC Protocol | Rotator Cuff/UQ Protocol | Hand Therapy |
| Core-Spinal Stabilization | Sport Specific Training | Pediatric Therapy |
| Patellofemoral Protocol | MFx/OATS/ACI Rehab | Vestibular Rehabilitation |
| Disability Awareness | Medical Assisted Training | Ergonomic Evaluation |

| | | | | |
|---|---|---|---|---|
| Frequency: | 1X | 2X | 3X | Daily |
| Duration: | _____ Weeks | | _____ Months | |

**Physician Authorization**

I certify______ recertify _______that I have examined the patient and physical therapy is medically necessary. I will review the treatment plan every 30 days.

Please send report Please Call Patient should recheck in ___weeks

Physician's signature: _______________________________ Date: _____________________