



We are located in the Cedarview Plaza on State Route 410 E. Please call if you need further directions. We have dedicated disabled parking and are fully ADA accessible. We look forward to meeting your rehabilitative needs.

Bonney Lake Physical Therapy and Hand Rehab is a provider for the following Insurance groups: Labor and Industries, Regence, Premera Blue Cross, Aetna, First Choice Health, Cigna, Uniform Medical Plan, Medicare, Medicaid, Tricare, including ALL auto insurance policies and PIP. All other insurances billed at patient's request.

Physical Therapy & Hand Rehab, PLLC

20910 State Route 410 E Bonney Lake, WA 98391
 www.BonneyLakeTherapy.com
 Phone: (253) 862-2575 Fax: (253) 862-2675

Michael Egbert, P.T. **Brandy Campbell OTR/L, CHT**
Physical Therapist *Certified Hand Therapist*

Name: _____ Date: _____

Diagnosis: _____

Date of Injury / Surgery: _____

Claim Number: _____

Evaluate & Treat per therapist's discretion.

Treatment Frequency: _____ Duration: _____

Precautions/Special Instructions: _____

Goals: _____

MODALITIES	PROCEDURES	EDUCATION
<input type="checkbox"/> Ultrasound	<input type="checkbox"/> Massage/MFR/Scar tx	<input type="checkbox"/> Home Exer. Prog.
<input type="checkbox"/> E. Stim./Muscle EGS	<input type="checkbox"/> Joint Mobilization	<input type="checkbox"/> Posture Retraining
<input type="checkbox"/> TENS	<input type="checkbox"/> Therapeutic Exercises	<input type="checkbox"/> Back Education
<input type="checkbox"/> Traction	<input type="checkbox"/> Neuromuscular Re-ed.	<input type="checkbox"/> Caregiver Training
<input type="checkbox"/> Heat/Cold	<input type="checkbox"/> Orthotic/Prosthetic Training	<input type="checkbox"/> Work Conditioning
<input type="checkbox"/> Paraffin	<input type="checkbox"/> Kinetic/Physio-Taping	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Biofeedback	<input type="checkbox"/> Gait Training	
<input type="checkbox"/> Fluidotherapy	<input type="checkbox"/> Wound Care/Pin Care	<input type="checkbox"/> Edema management
SPLINTING	<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Flexion blocking	<input type="checkbox"/> Thumb spica: Forearm-based / Hand-based	
<input type="checkbox"/> Extension blocking	<input type="checkbox"/> Wrist immobilizer / cock up	
<input type="checkbox"/> Trigger finger	<input type="checkbox"/> Tennis elbow brace	
<input type="checkbox"/> Mallet finger	<input type="checkbox"/> Muenster / Elbow	
<input type="checkbox"/> Boutonniere	<input type="checkbox"/> Static progressive / Dynamic mobilization splint	

Physician Signature: _____ Date: _____