



**COHESIVE HEALTHCARE MANAGEMENT & CONSULTING**

**Mangum Regional Medical Center**

TITLE		POLICY	
<b>Phonophoresis</b>		<b>816</b>	
MANUAL	EFFECTIVE DATE	REVIEW DATE	
<b>Rehabilitation</b>			
DEPARTMENT	REFERENCE		
<b>Rehabilitation Services</b>			

**SCOPE:** All professional rehabilitation staff utilizing phonophoresis for patient care at Mangum Regional Medical Center.

**PURPOSE:** To ensure that all phonophoresis treatments are administered safely and effectively within established guidelines.

**DEFINITION:** Phonophoresis is the movement of a substance into the underlying tissues, away from the patient surface of the transducer, by virtue of having been exposed to ultrasonic energy.

**POLICY:** Physician order received

- Order must be specific for “phonophoresis” or state evaluate and treat as indicated and initial evaluation certified by Physician prior to initiation of treatment.

Indications:

- As per Rehabilitation Services Policy: Ultrasound
- Pathologies involving inflammation and/or pus

Contraindications:

- As per Rehabilitation Services Policy: Ultrasound
- Allergy to topical agent ordered

Follow Rehabilitation Services Policy and Procedure: “Use of Medication” and “ultrasound”.

**PROCEDURE:**

1. Before initiating treatment, the patient is evaluated by therapist to determine appropriateness of the treatment.
  - a. Verify medication allergies.
2. Obtain topical agent per facility procedure.
  - a. Verify patient name, medication name, and physician order.
3. Treatment explained to patient.

- a. position and drape the patient for comfort, modesty and ease of accessibility keeping the part to be treated exposed.
  - b. Apply topical agent to treatment area with a tongue depressor, or directly through the bottle without making contact to patient's skin.
  - c. Apply coupling agent over topical agent.
  - d. Follow ultrasound treatment procedures as outlined in Rehabilitation Services Policy and Procedure: ultrasound.
4. **TOPICAL AGENT GUIDELINE IF NOT SPECIFIED PER M.D.**
- a. Initial treatment should consist of Myoflex 10% cream for a daily treatment for six days.
  - b. If patient does not get adequate relief: use Hydrocortisone (HC) 10% cream (or other facility approved steroidal cream/gel i.e. Dexamethasone), for daily treatment for six days.
  - c. If the patient gets adequate relief, discontinue treatment.
  - d. If the patient does not receive adequate relief, continue HC 10% cream 3 times/wk for 2 weeks.
5. Discontinue treatment if not successful accept:
- a. I for patient with clear signs and symptoms of nerve root or spinal cord impingement, treatment may continue on an indefinite basis one time per week period
6. For patient other than identified in 4.1, phonophoresis with HC 10% cream should not exceed 12 treatments.

**REVISIONS/UPDATES**

<b>Date</b>	<b>Brief Description of Revision/Change</b>