McLaren Business Products

McLaren Print System Order

Order No: 53225
Order Date: 2020-03-10
User: Krystin Wolschleger
Phone: (989)269-2599

Ship Location: McLaren Thumb Region: Attn: Krystin Wolschleger, Manager of Rehabilitation
1100 S. Van Dyke
Bad Axe, MI 48413,

Forms
Quantity: 5
Paragon Dept No: 030
Dept Name: Physical Therapy Department
Company Number: 530

Order Total Price: 50.00

Item Number: MTR-001
Item Description: REHAB OUTPATIENT REFERRAL
Revision Date: 9/2019
Print:
Paper:
Size:
Fold:
Finish:
Drill:
Misc Info: ss; color; pads of 50 - order per pad

THUMB REGION

REHABILITATION SERVICES OUTPATIENT REFERRAL

Patient Name: ______ Date of Birth: ______

Diagnosis: ______

Precautions/Comments: ______

Your therapy evaluation is scheduled for: Date: ______ Time: ______

PLEASE ARRIVE 15 MINUTES BEFORE YOUR APPOINTMENT TO GO THROUGH CENTRAL REGISTRATION
Please check with your insurance company for therapy coverage. Notify the therapy office if any prior authorization is needed. If you have questions please call 989-269-1540.

PHYSICAL THERAPY
- ❑ Evaluation and Treatment
  - ❑ Gait training, WB Bearing status ______
  - ❑ Therapeutic exercise/activities
  - ❑ Neuromuscular re-education
  - ❑ Manual therapy techniques
  - ❑ Balance/vestibular training
  - ❑ Instruct in Body Mechanics/ Ergonomic Instruction
  - ❑ Orthotics/Prosthetic training
  - ❑ Women's Health/Pelvic Floor Posture work
  - ❑ Other ______

OCCUPATIONAL THERAPY
- ❑ Evaluation and Treatment
  - ❑ ADL training
  - ❑ Cognitive/Perceptual training
  - ❑ Therapeutic exercise/Activities
  - ❑ Neuromuscular reeducation
  - ❑ Manual therapy techniques
  - ❑ Orthotics/Prosthetic training
  - ❑ Splinting - Dynamic ______
    Static ______
  - ❑ Other ______

MODALITIES (AS NEEDED)
- ❑ Ultrasound /phonophoresis
- ❑ Electrical stimulation/TENS
- ❑ Iontophoresis w/ ______
- ❑ Moist heat/ice
- ❑ Traction Cervical/lumbar
  - ❑ Manual ❑ Mechanical
- ❑ Biofeedback

SPEECH THERAPY
- ❑ Evaluation & Treatment
- ❑ Aphasia/Language
- ❑ Swallow function/Dysphagia
- ❑ Modified Barium Swallow radiograph/Clinical Evaluation
- ❑ Cognitive Skills
- ❑ Sensory Integrative Techniques
- ❑ Speech fluency
- ❑ Hearing/Audiogram screening
- ❑ Electronic augmentative device
- ❑ Voice deficit
- ❑ Other ______

Frequency: ______ times per week Duration: ______ weeks

Physician Signature: ______ Date: ______

Physician's Name (printed): ______

REHAB SERVICES OUTPATIENT REFERRAL

Spec Info: