

**McLaren Print System Order**

Order No: 7290  
 Order Date: 2014-11-21  
 User: Susan Hillger  
 Phone: 810-397-3103

Ship Location: McLaren Flint - FlushingPT  
 2500 North Elms  
 Flushing, MI 48433

**Forms**

Quantity: 500  
 Paragon Dept No: 38113  
 Dept Name: McLaren Flint - Flushing PT  
 Company Number: 60

Order Total Price: 32.40

Item Number: M-1784 B  
 Item Description: Physical, Occupational, or Speech Therapy Prescription  
 Revision Date: 8/2012  
 Print: 2 sided black and white  
 Paper: 20# White Text  
 Size: 8.5 x 11  
 Fold:  
 Finish: Padded (25 Sheets Per Pad)  
 Drill: None  
 Misc Info:

MCLAREN FLINT  
 810-397-3103

**PHYSICAL, OCCUPATIONAL, OR SPEECH THERAPY PRESCRIPTION**

Patient: \_\_\_\_\_ Age: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

FREQUENCY  Daily  Three X Weekly  Two X Weekly  \_\_\_\_\_ Duration: \_\_\_\_\_

<input type="checkbox"/> <b>PHYSICAL THERAPY</b>	<input type="checkbox"/> <b>OCCUPATIONAL THERAPY</b>	<input type="checkbox"/> <b>SPEECH THERAPY</b>
<input type="checkbox"/> Evaluation and Treatment	<input type="checkbox"/> Evaluation and Treatment	<input type="checkbox"/> Evaluation and Treatment
<input type="checkbox"/> Exercise	<input type="checkbox"/> Exercise	<input type="checkbox"/> Enduring Evaluation and Treatment
<input type="checkbox"/> Gait Training	<input type="checkbox"/> Splinting	<input type="checkbox"/> Work/Economy Selfie Study and Treatment
<input type="checkbox"/> Non wt. bearing L R	<input type="checkbox"/> Activities of Daily Living	<input type="checkbox"/> Voice Prosthetic Fitting and Treatment
<input type="checkbox"/> Toe touch wt. L R	<input type="checkbox"/> Homecoming	<input type="checkbox"/> Diagnostic Voice Evaluation and Treatment
<input type="checkbox"/> Partial wt. bearing L R	<input type="checkbox"/> Cognitive/Perceptual Training	
<input type="checkbox"/> Full wt. bearing L R	<input type="checkbox"/> Home Instructions	
<input type="checkbox"/> Home Instructions	<input type="checkbox"/> Driving Assessment	
<input type="checkbox"/> Postural/Body Mechanics Instructions	<input type="checkbox"/> Swallow Management	
<input type="checkbox"/> Joint Mobilization	<input type="checkbox"/> Joint Mobilization	
<input type="checkbox"/> Bender/Cyber Joint Evaluation	<input type="checkbox"/> Joint Protection and Energy Conservation	
<input type="checkbox"/> Computational Balance Assessment		
<input type="checkbox"/> Aquatic Therapy (during ONC)		

<b>MODALITIES</b> <input type="checkbox"/> Ultrasound <input type="checkbox"/> Electrical Stimulation <input type="checkbox"/> Phonophoresis (specify medication) <input type="checkbox"/> Hydrocortisone 10% gel <input type="checkbox"/> Other <input type="checkbox"/> Cold/Heat <input type="checkbox"/> Mass/Heat	<input type="checkbox"/> Traction Weight _____ <input type="checkbox"/> Massage <input type="checkbox"/> TENS <input type="checkbox"/> Acupuncture (specify modality) <input type="checkbox"/> Dexamethasone Inj/ml <input type="checkbox"/> Acetic Acid 1% acid <input type="checkbox"/> Other _____	<input type="checkbox"/> Round/Cone <input type="checkbox"/> Phoniatrics <input type="checkbox"/> Ultrasound Light (LHR) <input type="checkbox"/> Parallel <input type="checkbox"/> Serial Casting <input type="checkbox"/> Contrast Bath <input type="checkbox"/> Rhyth
---	---	--

Other: \_\_\_\_\_

Noted Precautions if Any: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

PHYSICAL THERAPY, OCCUPATIONAL THERAPY  
 OR SPEECH THERAPY PRESCRIPTION

11

11

11