

McLaren Print System Order

Order No: 8197
 Order Date: 2015-01-14
 User: Kellie Stites
 Phone: 810-342-5374

Ship Location: NRI- Bristol Place
 4466 Bristol Rd
 Flint, MI 48507

Forms

Quantity: 500
 Paragon Dept No: 38260
 Dept Name: Neuro Rehab Institute
 Company Number: 60

Order Total Price: 0.00

Item Number: M-1784 N
 Item Description: Neurologic Rehabilitation Institute Prescription
 Revision Date: 2/2012
 Print: 2 sided black and white
 Paper: 20# White Text
 Size: 8.5 x 11
 Fold:
 Finish:
 Drill: None
 Misc Info:

MCLAREN FLINT
 NEUROLOGIC REHABILITATION INSTITUTE PRESCRIPTION
 4466 BRISTOL RD, SUITE B, FLINT, MI 48507
 PHONE: (810) 342-5374 FAX: (810) 342-5456

Patient _____ DOB _____ Age _____
 Diagnosis _____ Doctor _____ Date _____

<input type="checkbox"/> PHYSICAL THERAPY Evaluation and Treatment <input type="checkbox"/> Frequency/Duration _____ <input type="checkbox"/> Gait/Balance Evaluation <input type="checkbox"/> Therapeutic Exercise <input type="checkbox"/> Self Training <input type="checkbox"/> Balance/Coordination Training <input type="checkbox"/> Functional Activities <input type="checkbox"/> Postural/Body Mechanics Instruction <input type="checkbox"/> Wheelchair Management <input type="checkbox"/> Computerized Balance Assessment <input type="checkbox"/> Home Instructions <input type="checkbox"/> Orthotic/Prosthetic Training <input type="checkbox"/> Community Reintegration <input type="checkbox"/> Joint Mobilization <input type="checkbox"/> Other _____	<input type="checkbox"/> OCCUPATIONAL THERAPY Evaluation and Treatment <input type="checkbox"/> Frequency/Duration _____ <input type="checkbox"/> Strengthening/Flexibility <input type="checkbox"/> Fine Motor Coordination <input type="checkbox"/> Activities of Daily Living <input type="checkbox"/> Self-Care/Kitchen Management <input type="checkbox"/> Visual/Perceptual Relearning <input type="checkbox"/> Independent Community Mobility <input type="checkbox"/> Community Re-entry <input type="checkbox"/> Other _____	<input type="checkbox"/> SPEECH THERAPY Evaluation and Treatment <input type="checkbox"/> Frequency/Duration _____ <input type="checkbox"/> Bedside Swallowing Evaluation <input type="checkbox"/> Diagnostic Voice Evaluation <input type="checkbox"/> Alternative/Supplemental Communication Eval & Treatment <input type="checkbox"/> Aphasia Treatment <input type="checkbox"/> Higher Linguistic Integration Skills <input type="checkbox"/> Right Hemisphere Communication Disorders <input type="checkbox"/> Motor Speech Disorders <input type="checkbox"/> Dysphagia <input type="checkbox"/> Other _____
<input type="checkbox"/> SOCIAL WORK Evaluation and Treatment <input type="checkbox"/> Frequency/Duration _____		<input type="checkbox"/> RECREATIONAL THERAPY Evaluation and Treatment <input type="checkbox"/> Frequency/Duration _____

MODALITIES

<input type="checkbox"/> Ultrasound	<input type="checkbox"/> Massage/Soft Tissue Mobilization	<input type="checkbox"/> Paraffin
<input type="checkbox"/> Electrical Stimulation	<input type="checkbox"/> TENS	<input type="checkbox"/> Serial Casting
<input type="checkbox"/> Phonophoresis	<input type="checkbox"/> Hydrophoresis	<input type="checkbox"/> Contrast Bath
<input type="checkbox"/> Cold/Heat	<input type="checkbox"/> Traction/Weight	<input type="checkbox"/> Modal Heat

Other _____

Noted Precautions if Any: _____

Physician's Signature: _____ Date: ____/____/____

NEUROLOGIC REHABILITATION INSTITUTE
 PRESCRIPTION

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