McLaren Business Products

McLaren Print System Order

Order No: 42911
Order Date: 2019-02-15
User: Susan Hillger
Phone: 248-866-2048

Ship Location: McLaren Flint PT (attn: Susan Hillger)
G-3239 Beecher Rd
Flint, MI 48532
Forms
Quantity: 500
Paragon Dept No: 38110
Dept Name: McLaren Flint PT
Company Number: 60

Order Total Price: 42.50

Item Number: M-1784 B
Item Description: Physical, Occupational, or Speech Therapy Prescription
Revision Date: 12/2016
Print: 1 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
Flint, Michigan
PHYSICAL, OCCUPATIONAL, OR SPEECH THERAPY PRESCRIPTION
Patient: _____ Age: _____
Diagnosis: _____
FREQUENCY: ☐ Daily ☐ Three X Weekly ☐ Two X Weekly ☐ _____ Duration: _____
☐ PHYSICAL THERAPY
☐ Evaluation and Treatment
☐ Exercise
☐ Gait Training
☐ Non wt. bearing L R
☐ Toe touch only L R
☐ Partial wt. bearing L R
☐ Full wt. bearing L R
☐ Home Instructions
☐ Posture/Body Mechanics Instructions
☐ Joint Mobilization
☐ Biodex/Cybex: Joint Evaluation
☐ Computerized Balance Assessment
☐ Aquatic Therapy (Pushing ONLY)
☐ OCCUPATIONAL THERAPY
☐ Evaluation and Treatment
☐ Exercise
☐ Splinting
☐ Activities of Daily Living
☐ Homemaking
☐ Cognitive/Perceptual Training
☐ Home Instructions
☐ Driving Assessment
☐ Scar Management
☐ Joint Mobilization
☐ Joint Protection and Energy Conservation
☐ SPEECH THERAPY
☐ Evaluation and Treatment
☐ Swallowing Evaluation and Treatment
☐ Videofluoroscopy Swallow Study and Treatment
☐ Voice Prosthetic Fitting and Treatment
☐ Diagnostic Voice Evaluation and Treatment
MODALITIES
☐ Ultrasound
☐ Electrical Stimulation
☐ Phonophoresis (specify medication)
☐ Hydrocortisone 10% gel
☐ Other _____
☐ Cold Pack
☐ Moist Heat
☐ Traction Weight _____
☐ Massage
☐ TENS
☐ Iontophoresis (specify medications)
☐ Dexamethasone 4mg/ml
☐ Acetic Acid 5% soln
☐ Other _____
☐ Wound Care
☐ Fluidotherapy
☐ Ultraviolet Light (UVB)
☐ Paraffin
☐ Serial Casting
☐ Contrast Bath
☐ PUVA
Other: _____
Noted Precautions if Any: _____
Physician's printed name: _____
Physician's Signature: _____ Date: ____/____/____
PHYSICAL THERAPY, OCCUPATIONAL THERAPY OR SPEECH THERAPY PRESCRIPTION
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Spec Info: