

McLaren Print System Order

Order No: 48664
 Order Date: 2019-09-17
 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,

Brochures
 Quantity: 3
 Paragon Dept No: 030
 Dept Name: Physical Therapy Department
 Company Number: 530

Order Total Price: 30.00

Item Number: MTR-001
 Item Description: REHAB OUTPATIENT REFERRAL
 Revision Date: 8/2018
 Print:
 Paper:
 Size:
 Fold:
 Finish:
 Drill:
 Misc Info: ss; color; pads of 50 - order per pad



1100 S. Van Dyke • Bad Axe, Michigan 48413
 Phone: (989) 269-1540 • Fax: (989) 269-2628 • www.mclaren.org/thumbregion

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 989-269-4933 ext. 4395.

PHYSICAL THERAPY <input type="checkbox"/> Evaluation and Treatment <input type="checkbox"/> Gait training, WB bearing status <input type="checkbox"/> Therapeutic exercise/activities <input type="checkbox"/> Neuromuscular re-education <input type="checkbox"/> Manual therapy techniques <input type="checkbox"/> Balance/Vestibular training <input type="checkbox"/> Instruct in Body Mechanics/Ergonomic instruction <input type="checkbox"/> Orthotics/Prosthetic training <input type="checkbox"/> Women's health/Pelvic Floor Posture work <input type="checkbox"/> Other _____	OCCUPATIONAL THERAPY <input type="checkbox"/> Evaluation and Treatment <input type="checkbox"/> ADL training <input type="checkbox"/> Cognitive/Perceptual training <input type="checkbox"/> Therapeutic exercise/Activities <input type="checkbox"/> Neuromuscular re-education <input type="checkbox"/> Manual therapy techniques <input type="checkbox"/> Orthotics/Prosthetic training <input type="checkbox"/> Splinting - Dynamic _____ <input type="checkbox"/> Static _____ <input type="checkbox"/> Other _____
MODALITIES (AS NEEDED) <input type="checkbox"/> Ultrasound/Phonophoresis <input type="checkbox"/> Electrical stimulation/TENS <input type="checkbox"/> Iontophoresis w/ _____	<input type="checkbox"/> Moist heat/ice <input type="checkbox"/> Traction Cervical/Lumbar <input type="checkbox"/> Manual <input type="checkbox"/> Mechanical <input type="checkbox"/> Biofeedback
SPEECH THERAPY Assessment and treatment for: <input type="checkbox"/> Articulation/language <input type="checkbox"/> Swallow function/Dysphagia <input type="checkbox"/> Modified Barium Swallow radiograph <input type="checkbox"/> Cognitive skills	<input type="checkbox"/> Sensory Integrative Techniques <input type="checkbox"/> Speech Fluency <input type="checkbox"/> Hearing/Audiogram screening <input type="checkbox"/> Electronic augmentative device <input type="checkbox"/> Voice Affect <input type="checkbox"/> Other _____

Frequency: _____ times per week Duration: _____ weeks
 Physician Signature: _____ Date: _____
 Physician's Name (printed): _____

Spec Info: