

McLaren Print System Order

Order No: 50810
Order Date: 2019-12-05
User: Susan Hillger
Phone: 248-866-2048

Ship Location: McLaren PT (Susan Hillger)
G-3239 Beecher
Flint, MI 48532

Forms

Quantity: 500
Paragon Dept No: 38110
Dept Name: McLaren Flint
Company Number: 60

Order Total Price: 32.40

Item Number: M-1784 B
Item Description: Physical, Occupational, or Speech Therapy Prescription
Revision Date: 12/2016
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
500 Sheets
PHYSICAL, OCCUPATIONAL, OR SPEECH THERAPY PRESCRIPTION

Patient: _____ Age: _____

Diagnosis: _____

FREQUENCY: Daily Three X Weekly Two X Weekly _____ Duration: _____

<input type="checkbox"/> PHYSICAL THERAPY	<input type="checkbox"/> OCCUPATIONAL THERAPY	<input type="checkbox"/> SPEECH THERAPY
<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"/> Swallowing Evaluation and Treatment
<input type="checkbox"/> Gait Training	<input type="checkbox"/> Splinting	<input type="checkbox"/> Video/Kinesiology Swallow 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 only L, R	<input type="checkbox"/> Home-making	<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"/> Scar Management	
<input type="checkbox"/> Joint Mobilization	<input type="checkbox"/> Joint Mobilization	
<input type="checkbox"/> Biomechanical Joint Evaluation	<input type="checkbox"/> Joint Protection and Energy Conservation	
<input type="checkbox"/> Computerized Balance Assessment		
<input type="checkbox"/> Aquatic Therapy (using ONLY)		

MODALITIES <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-Pack <input type="checkbox"/> Moist Heat	<input type="checkbox"/> Traction Weight _____ <input type="checkbox"/> Massage <input type="checkbox"/> TENS <input type="checkbox"/> Iontophoresis (specify medication) <input type="checkbox"/> Desmethylaurea Bromide <input type="checkbox"/> Acetic Acid 5% soth <input type="checkbox"/> Other _____	<input type="checkbox"/> Sound-Cone <input type="checkbox"/> Fluorotherapy <input type="checkbox"/> Ultraviolet Light (A/B/C) <input type="checkbox"/> Paraffin <input type="checkbox"/> Serial Casting <input type="checkbox"/> Contrast Bath <input type="checkbox"/> Pylus
--	---	---

Other: _____

Spec Info:

Noted Precautions if Any: _____

Physician's printed name: _____

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

PHYSICAL THERAPY, OCCUPATIONAL THERAPY
OR SPEECH THERAPY PRESCRIPTION

500