McLaren Business Products

McLaren Print System Order

Order No: 52355
Order Date: 2020-02-05
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,
Forms
Quantity: 4
Paragon Dept No: 030
Dept Name: Physical Therapy Department
Company Number: 530

Order Total Price: 40.00

Item Number: MTR-001
Item Description: REHAB OUTPATIENT REFERRAL
Revision Date: 9/2019
Print:
Paper:
Size:
Fold:
Finish:
Drill:
Misc Info: ss; color; pads of 50 - order per pad

Spec Info:

McLaren
THUMB REGION

1100 S. Van Dyke • Bad Axe, Michigan 48413
Phone: (989) 269-1540 – Fax: (989) 269-2658 – 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 989-269-1540.

PHYSICAL THERAPY
- ❑ Evaluation and Treatment
- ❑ Gait training, Wt Bearing status _____
- ❑ Therapeutic exercise/activities
- ❑ Neuromuscular re-education
- ❑ Manual therapy techniques
- ❑ Balance/vestibular training
- ❑ Instruct in Body Mechanics/ Ergonomic Instruction
- ❑ Orthotics/Prosthetic training
- ❑ Women's Health/Pelvic Floor Posture work
- ❑ Other _____

OCCUPATIONAL THERAPY
- ❑ Evaluation and Treatment
- ❑ ADL training
- ❑ Cognitive/Perceptual training
- ❑ Therapeutic exercise/Activities
- ❑ Neuromuscular reeducation
- ❑ Manual therapy techniques
- ❑ Orthotics/Prosthetic training
- ❑ Splinting – Dynamic _____ Static _____
- ❑ Other _____

MODALITIES: (AS NEEDED)
- ❑ Ultrasound/ Iphonophoresis
- ❑ Electrical stimulation/TENS
- ❑ Iontophoresis w/_____
- ❑ Moist heat/ice
- ❑ Traction: Cervical/lumbar ❑ Manual ❑ Mechanical
- ❑ Biofeedback

SPEECH THERAPY
- ❑ Evaluation & Treatment
- ❑ Aphasia/Language
- ❑ Swallow function/Dysphagia
- ❑ Modified Barium Swallow radiograph/Clinical Evaluation
- ❑ Cognitive Skills
- ❑ Sensory integrative Techniques
- ❑ Speech fluency
- ❑ Hearing/Audiogram screening
- ❑ Electronic augmentative device
- ❑ Voice deficit
- ❑ Other _____

Frequency: _____ times per week Duration: _____ weeks

Physician Signature: _____ Date: _____

Physician's Name (printed): _____

REHAB SERVICES OUTPATIENT REFERRAL