

McLaren Print System Order

Order No: 52441 Reprint Previous Order No: 8107
 Order Date: 2020-02-07
 User: shelby brandon
 Phone: 810-342-2362

Ship Location: McLaren Flint 1 North Therapy Services Attention: Shelby Brandon
 401 S. Ballenger Hwy
 Flint, MI 48532

Forms

Quantity: 100
 Paragon Dept No: 38113
 Dept Name: McLaren Flint Flushing Physical Therapy
 Company Number: 60

Order Total Price: 0.00

Item Number: M-1784 N
 Item Description: NRI Prescription
 Revision Date: 2/2017
 Print: 2 sided black and white
 Paper: 20# White Text
 Size: 8.5 x 11
 Fold:
 Finish: None
 Drill: None
 Misc Info:

MCLAREN FLINT
 NEUROLOGIC REHABILITATION INSTITUTE PRESCRIPTION
 401 S. BALLINGER HWY, FLINT, MI 48532
 PHONE (810) 342-4338 • FAX (810) 342-4338

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

<input type="checkbox"/> PHYSICAL THERAPY Evaluation and Treatment <input type="checkbox"/> Frequency/Duration: _____	<input type="checkbox"/> OCCUPATIONAL THERAPY Evaluation and Treatment <input type="checkbox"/> Frequency/Duration: _____	<input type="checkbox"/> SPEECH THERAPY Evaluation and Treatment <input type="checkbox"/> Frequency/Duration: _____
<input type="checkbox"/> Wheelchair Evaluation <input type="checkbox"/> Therapeutic Exercise <input type="checkbox"/> Gait Training <input type="checkbox"/> Balance/Coordination Training <input type="checkbox"/> Functional Activities <input type="checkbox"/> Postural/Body Mechanics Instructions <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"/> Strengthening/Flexibility <input type="checkbox"/> Fine Motor Coordination <input type="checkbox"/> Activities of Daily Living <input type="checkbox"/> Self-Care/Home Management <input type="checkbox"/> Visual/Perceptual Retraining <input type="checkbox"/> Independent Community Mobility <input type="checkbox"/> Community Re-entry <input type="checkbox"/> Other: _____	<input type="checkbox"/> Bedside Swallowing Evaluation <input type="checkbox"/> Diagnostic Voice Evaluation <input type="checkbox"/> Alternative/Supplementative 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"/> Iontophoresis	<input type="checkbox"/> Contrast Bath
<input type="checkbox"/> Cold Pack	<input type="checkbox"/> Traction Weight	<input type="checkbox"/> Moist Heat

Other: _____

Noted Precautions if Any: _____

Physician's Signature: _____ Date: _____

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 PRESCRIPTION
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