McLaren Business Products

McLaren Print System Order

Order No: 52443 Reprint Previous Order No: 6547
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: 500
Paragon Dept No: 38110
Dept Name: McLaren Flint Outpatient Physical Therapy
Company Number: 60

Order Total Price: 0.00

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: None
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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