

**McLaren Print System Order**

Order No: 45142  
 Order Date: 2019-05-06  
 User: Susan Hillger  
 Phone: 248-866-2048

Ship Location: McLaren NRI (attn: Kelli Baker)  
 G-3239 Beecher  
 Flint, MI 48532

**Forms**

Quantity: 500  
 Paragon Dept No: 38260  
 Dept Name: McLaren NRI  
 Company Number: 60

Order Total Price: 32.40

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: Padded (25 Sheets Per Pad)  
 Drill: None  
 Misc Info:

MCLAREN-FLINT  
 NEUROLOGIC REHABILITATION INSTITUTE PRESCRIPTION  
 32329 BEECHER ROAD, FLINT, MI 48532  
 Phone: (810) 342-4222 • Fax: (810) 342-4338

Patient: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_  
 Degree: \_\_\_\_\_ Sector: \_\_\_\_\_ Date: \_\_\_\_\_

<input type="checkbox"/> <b>PHYSICAL THERAPY</b> Evaluation and Treatment <input type="checkbox"/> Frequency/Duration: _____	<input type="checkbox"/> <b>OCCUPATIONAL THERAPY</b> Evaluation and Treatment <input type="checkbox"/> Frequency/Duration: _____	<input type="checkbox"/> <b>SPEECH THERAPY</b> 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"/> <b>SOCIAL WORK</b> Evaluation and Treatment <input type="checkbox"/> Frequency/Duration: _____	<input type="checkbox"/> <b>RECREATIONAL THERAPY</b> 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: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Spec Info:**

NEUROLOGIC REHABILITATION INSTITUTE PRESCRIPTION  
 61764-017

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