

McLaren Print System Order

Order No: 57836
 Order Date: 2020-10-23
 User: Susan Hillger
 Phone: 248-866-2048

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

Forms

Quantity: 100
 Paragon Dept No: 38110
 Dept Name: McLaren Flint
 Company Number: 60

Order Total Price: 8.50

Item Number: M-1784 B
 Item Description: Physical, Occupational, or Speech Therapy Prescription
 Revision Date: 12/2016
 Print: 1 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
800-367-6848

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"/> Evaluation and Treatment <input type="checkbox"/> Exercise <input type="checkbox"/> Gait Training <input type="checkbox"/> Non wt. bearing L, R <input type="checkbox"/> Toe touch only L, R <input type="checkbox"/> Partial wt. bearing L, R <input type="checkbox"/> Full wt. bearing L, R <input type="checkbox"/> Home Instructions <input type="checkbox"/> Postural/Body Mechanics Instructions <input type="checkbox"/> Joint Mobilization <input type="checkbox"/> Biomechanical Joint Evaluation <input type="checkbox"/> Computerized Balance Assessment <input type="checkbox"/> Aquatic Therapy (using ONLY)	<input type="checkbox"/> OCCUPATIONAL THERAPY <input type="checkbox"/> Evaluation and Treatment <input type="checkbox"/> Exercise <input type="checkbox"/> Splinting <input type="checkbox"/> Activities of Daily Living <input type="checkbox"/> Homemaking <input type="checkbox"/> Cognitive/Perceptual Training <input type="checkbox"/> Home Instructions <input type="checkbox"/> Driving Assessment <input type="checkbox"/> Scar Management <input type="checkbox"/> Joint Mobilization <input type="checkbox"/> Joint Protection and Energy Conservation	<input type="checkbox"/> SPEECH THERAPY <input type="checkbox"/> Evaluation and Treatment <input type="checkbox"/> Swallowing Evaluation and Treatment <input type="checkbox"/> Video/Laryngoscopy Swallow Study and Treatment <input type="checkbox"/> Voice Prosthetic Fitting and Treatment <input type="checkbox"/> Diagnostic Voice Evaluation and Treatment
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MODALITIES			
<input type="checkbox"/> Ultrasound	<input type="checkbox"/> Traction Weight _____	<input type="checkbox"/> Sound/Care	<input type="checkbox"/> Serial Casting
<input type="checkbox"/> Electrical Stimulation	<input type="checkbox"/> Massage	<input type="checkbox"/> Fluidotherapy	<input type="checkbox"/> Contrast Bath
<input type="checkbox"/> Phonophoresis (specify medication)	<input type="checkbox"/> TENS	<input type="checkbox"/> Ultrasound Light (LMB)	<input type="checkbox"/> Pylus
<input type="checkbox"/> Hydrocortisone 10% gel	<input type="checkbox"/> Acetaminophen (specify medication)	<input type="checkbox"/> Ultraviolet Light (UVA)	<input type="checkbox"/> Paraffin
<input type="checkbox"/> Other _____	<input type="checkbox"/> Dexamethasone (specify)	<input type="checkbox"/> Paraffin	
<input type="checkbox"/> Code-Park	<input type="checkbox"/> Acetic Acid 5% acid		
<input type="checkbox"/> Moist Heat	<input type="checkbox"/> Other _____		

Other: _____

Spec Info: _____

Noted Precautions if Any: _____

Physician's printed name: _____

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

PHYSICAL THERAPY, OCCUPATIONAL THERAPY
OR SPEECH THERAPY PRESCRIPTION

650