

McLaren Print System Order

Order No: 7291
 Order Date: 2014-11-21
 User: Susan Hillger
 Phone: 810-397-3103

Ship Location: McLaren Flint - Bristol PT
 G-4466 W. Bristol Rd, 3rd floor, PT
 Fling, MI 48507

Forms

Quantity: 500
 Paragon Dept No: 38111
 Dept Name: McLaren Flint - Bristol PT
 Company Number: 60

Order Total Price: 32.40

Item Number: M-1784 B
 Item Description: Physical, Occupational, or Speech Therapy Prescription
 Revision Date: 8/2012
 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
 810-397-3103

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"/> OCCUPATIONAL THERAPY	<input type="checkbox"/> SPEECH THERAPY
<input type="checkbox"/> Evaluation and Treatment	<input type="checkbox"/> Evaluation and Treatment	<input type="checkbox"/> Evaluation and Treatment
<input type="checkbox"/> Exercise	<input type="checkbox"/> Exercise	<input type="checkbox"/> Enduring Evaluation and Treatment
<input type="checkbox"/> Gait Training	<input type="checkbox"/> Splinting	<input type="checkbox"/> Vibration/Electromyography Surface Study and Treatment
<input type="checkbox"/> Non wt. bearing L R	<input type="checkbox"/> Activities of Daily Living	<input type="checkbox"/> Voice Prosthetic Fitting and Treatment
<input type="checkbox"/> Toe touch wt. L R	<input type="checkbox"/> Homecoming	<input type="checkbox"/> Diagnostic Voice Evaluation and Treatment
<input type="checkbox"/> Partial wt. bearing L R	<input type="checkbox"/> Cognitive/Perceptual Training	
<input type="checkbox"/> Full wt. bearing L R	<input type="checkbox"/> Home Instructions	
<input type="checkbox"/> Home Instructions	<input type="checkbox"/> Driving Assessment	
<input type="checkbox"/> Postural/Body Mechanics Instructions	<input type="checkbox"/> Swallow Management	
<input type="checkbox"/> Joint Mobilization	<input type="checkbox"/> Joint Mobilization	
<input type="checkbox"/> Bender/Cyber Joint Evaluation	<input type="checkbox"/> Joint Protection and Energy Conservation	
<input type="checkbox"/> Computational Balance Assessment		
<input type="checkbox"/> Aquatic Therapy (during ONC)		

MODALITIES			
<input type="checkbox"/> Ultrasound	<input type="checkbox"/> Traction Weight _____	<input type="checkbox"/> Sound/Heat	<input type="checkbox"/> Serial Casting
<input type="checkbox"/> Electrical Stimulation	<input type="checkbox"/> Massage	<input type="checkbox"/> Phoniatrics	<input type="checkbox"/> Contrast Bath
<input type="checkbox"/> Phonophoresis (specify medication)	<input type="checkbox"/> TENS	<input type="checkbox"/> Ultrasound Light (LHR)	<input type="checkbox"/> Rhyth
<input type="checkbox"/> Hydrocortisone 10% gel	<input type="checkbox"/> Acetylcholinesterase (specify medication)	<input type="checkbox"/> Paraffin	
<input type="checkbox"/> Other _____	<input type="checkbox"/> Dexamethasone (specify)		
<input type="checkbox"/> Cold/Heat	<input type="checkbox"/> Acids Acid (7% acid)		
<input type="checkbox"/> Must Not	<input type="checkbox"/> Other _____		

Other: _____

Noted Precautions if Any: _____

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

PHYSICAL THERAPY, OCCUPATIONAL THERAPY
 OR SPEECH THERAPY PRESCRIPTION

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