McLaren Business Products

McLaren Print System Order

Order No: 90645
Order Date: 2024-12-06
Order Request Date:
User: Krystin Wolschleger
Phone: (989)269-1540

Ship Location: **McLaren Thumb Region: Attn: Krystin Wolschleger, Director of Rehabilitation**
1100 S. Van Dyke
Bad Axe, MI 48413,

Brochures
Quantity: 100
Paragon Dept No: 26900
Dept Name: Physical Therapy Department
Company Number:

Order Total Price: 16.35

Item Number: MTR-035
Item Description: REHAB OUTPATIENT REFERRAL
Revision Date: 10/2024
Print: 1 sided full color
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish: Padded (100 Sheets Per Pad)
Drill: None
Poster:
Misc Info: SS, Color

THUMB REGION

1100 S. Van Dyke • Bad Axe, Michigan 48413
Phone: (989) 269-1540 • Fax: (989) 269-2658 • www.mclaren.org/thumbregion

REHABILITATION SERVICES OUTPATIENT REFERRAL

Patient Name: ______________________ Date of Birth: __________

Diagnosis: ______________________

Precautions/Comments: ______________________

Your therapy evaluation is schedule for: Date: ______________ Time: __________

PLEASE ARRIVE 15 MINUTES BEFORE YOUR APPOINTMENT TO GO THROUGH CENTRAL REGISTRATION. Please check with your insurance company for therapy coverage. Notify the therapy office if any prior authorization is needed. If you have questions please call 989-269-1540.

PHYSICAL THERAPY
- ❑ Evaluation and Treatment
  - ❑ Gait training, Wt Bearing status __________
  - ❑ Therapeutic exercise/activities
  - ❑ Neuromuscular re-education
  - ❑ Manual therapy techniques
  - ❑ Balance/vestibular training
  - ❑ Instruct in Body Mechanics/Ergonomic instruction
  - ❑ Orthotics/Prosthetic training
  - ❑ Women's Health/Pelvic Floor Posture work
  - ❑ Other ______________

OCCUPATIONAL THERAPY
- ❑ Evaluation and Treatment
  - ❑ ADL training
  - ❑ Cognitive/Perceptual training
  - ❑ Therapeutic exercise/Activities
  - ❑ Neuromuscular reeducation
  - ❑ Manual therapy techniques
  - ❑ Orthotics/Prosthetic training
  - ❑ Splinting – Dynamic __________
    Static __________
  - ❑ Functional capacity evaluation
  - ❑ Work conditioning/hardening
  - ❑ Other ______________

MODALITIES: (AS NEEDED)
- ❑ Ultrasound/phonophoresis
- ❑ Electrical stimulation/TENS
- ❑ Iontophoresis w/ ______________
- ❑ Moist heat/ice
- ❑ Traction: Cervical/lumbar
  - ❑ Manual ❑ Mechanical
- ❑ Biofeedback

SPEECH THERAPY
- ❑ Evaluation & Treatment
- ❑ Aphasia/Language
- ❑ Oral/Swallow function/Dysphagia
- ❑ Modified Barium Swallow radiograph/Clinical Evaluation
- ❑ Cognitive Skills
- ❑ Sensory Integrative Techniques
- ❑ Speech fluency
- ❑ Hearing/Audiogram screening
- ❑ Electronic augmentative device
- ❑ Voice deficit
  - ❑ Other ______________

Spec Info: Please print 10 referral pads (100 pages per pad) and send to McLaren Thumb Outpatient Therapy 3rd floor.

Physician signature: ______________________ Date: __________

Physician's Name (printed): ______________________

REHABILITATION SERVICES OUTPATIENT REFERRAL