McLaren
MACOMB

PHYSICAL/OCCUPATIONAL/SPEECH THERAPY PRESCRIPTION

Clinton Township
21550 Harrington Street
Clinton Township, MI 48036
(586)783-9581
Fax To: (586) 783-9604

Patient Name: _____ D.O.B.: ___/___/___

Patient Phone Number: _____ Diagnosis: _____

Date of Onset: ___/___/___ Date of Surgery (if applicable): ___/___/___

Precautions/Contraindications: _____

☐ **Physical Therapy**
- ☐ Evaluate patient, develop a plan of care, and implement plan
  - ☐ PROM-AROM
  - ☐ Therapeutic Exercise
  - ☐ Joint Mobilization
  - ☐ Neuromuscular Re-ed
  - ☐ Gait Training
  - ☐ Balance Training
  - ☐ Vestibular Training
  - ☐ Incontinence Retraining
  - ☐ Pelvic Floor Rehab

☐ **Occupational Therapy**
- ☐ Evaluate patient, develop a plan of care, and implement plan
  - ☐ PROM-AROM
  - ☐ Therapeutic Exercise
  - ☐ Joint Mobilization
  - ☐ Neuromuscular Re-ed
  - ☐ ADL Training

SPLINT:
- ☐ Evaluate and Construct
- ☐ Type: _____

☐ **Speech / Language Pathology**
- ☐ Evaluate patient, develop a plan of care, and implement plan
  - ☐ Swallow Treatment
  - ☐ Other:

Speech/Language Diagnosis:
- ☐ Articulation Disorder
- ☐ Cognitive Deficits
- ☐ Aphasia
- ☐ Dysphonia, Hoarseness Hyper/Hyponasality
- ☐ Dysarthria

MODALITIES:
- ☐ Ultrasound
- ☐ Fluidotherapy
- ☐ Traction
- ☐ Electrical Stimulation
- ☐ Infra-red Light Therapy
- ☐ Iontophoresis (please give patient script for medication)
- ☐ Phonophoresis (please give patient script for medication)

Other:

Duration: _____ weeks

Frequency: _____ times per week

I certify that I have examined the patient and therapy is medically necessary.

Physician's Signature: _____ Date: ___/___/___ Time: _____

Physician Name : _____
(please print)