



REHABILITATION SERVICES

Phone: 931-815-4367 • Fax: 931-815-4630

www.riverparkhospital.com

Instructions:

- Fax order to 931-815-4630
- Original – To be kept in the office chart.
- Make a copy for the patient to bring to the facility on the day of the exam.

PHYSICAL THERAPY **OCCUPATIONAL THERAPY** **SPEECH THERAPY**

Patient Name: _____

Diagnosis: _____

Precautions: _____

Insurance authorization #: _____

PLAN OF CARE

EVALUATE AND TREAT PHYSICAL THERAPY AND/OR OCCUPATIONAL THERAPY

Therapeutic Exercise

- Passive ROM
- Active ROM
- Progressive Resistive
- Home Exercise Program
- PNF
- NDT
- Lumbar Stabilization
- Neuromuscular Reeducation
- Balance Training/Education
- Other _____

Modalities

- Hot/Cold Pack
- Ultrasound
- Lontophoresis
- Traction
- Electrical Stimulation
- TENS
- Vasopneumatic Compression
- Biofeedback Training
- Fluidotherapy
- Paraffin Bath
- Other _____

Other

- Joint Mobilization
- Myofascial Release/Massage
- Gait Training
- WB Status _____
- Splint Dynamic
 Static
- Wound Care
- Isokinetic Training/Testing

EVALUATE AND TREAT SPEECH THERAPY

- Video fluoroscopic swallowing study and dysplasia treatment (ST)
- Aphasia evaluation and treatment (ST)
- Cognitive evaluation and treatment (ST)
- Voice evaluation and treatment (ST)
- Fluency evaluation and treatment (ST)
- Motor speech (Dysarthria/Apraxia) evaluation and treatment (ST)
- Laryngectomy (Pre or Post Counseling) evaluation and treatment (ST)
- Traumatic brain injury evaluation and treatment (ST)
- Other

Specific Instructions: _____

FREQUENCY / DURATION

Per therapist discretion ____ x week for ____ weeks

I authorize that the above services are medically necessary.

Physician Signature: _____ Date: _____