THERAPY SERVICES OUTPATIENT REFERRAL

MASONIC HOMES of KENTUCKY

Please select location:

❒ Louisville Rehab Center
3503 Moyers Circle
Fax: (502) 873-2312
Phone: (502) 753-8850

❒ Shelbyville Rehab Center
711 Frankfort Road
Fax: (502) 633-0661
Phone: (502) 513-1875

❒ Sproutlings Pediatric Day Care
3800 Tom Larimore Drive
Fax: (502) 753-8223
Phone: (502) 753-8222

Name: _____ Date: _____

Diagnosis _____

_____

ICD-9 DX CODE: _____ No. of treatments per week: _____ for _____weeks

Goals

Relief of pain	❒	Improve function	❒	Improve communication	❒
Decrease edema	❒	Improve strength	❒	Improve swallowing	❒
Increase dynamic balance	❒	Increase ROM	❒		

Contraindications/Precautions or Special Instructions _____

_____

Weight bearing status: _____ Left _____ Right _____

PHYSICIAN ORDERS

❒ **PHYSICAL THERAPY** evaluate and treat as indicated
❒ **OCCUPATIONAL THERAPY** evaluate and treat as indicated
❒ **SPEECH THERAPY** evaluate and treat as indicated

PHYSICAL THERAPY

Therapeutic Exercises	❒
Strengthening	❒
Gait Training	❒
Ultrasound	❒
Paraffin	❒
Electrical Stimulation	❒
TENS	❒
Phonophoresis	❒
Manual Therapy	❒
Balance Retraining	❒
Iontophoresis	❒
Transfer Skills	❒
Postural Exercise	❒
Home Exercise Program	❒
Other	❒

OCCUPATIONAL THERAPY

Therapeutic Exercises	❒
Scar Massage	❒
ADL Training	❒
Joint Protection Instruction	❒
Splinting	❒
Home Exercise Program	❒
Electrical Stimulation	❒
Paraffin	❒
Manual/Motor Wheelchair Evaluation	❒
Seating & Repositioning	❒
Neuromuscular Re-education	❒
Fine Motor Coordination	❒
Sensory Integration	❒
Modalities	❒

SPEECH THERAPY

Oral Motor Therapy	❒
Expressive/Receptive Language Therapy	❒
Vital Stim	❒
Cognitive Therapy	❒
Augmentature & Alternative Communication Evaluation & Training	❒
Other	❒

I certify that this patient is under my care and that the above outpatient services are medically necessary.

_____ _____

Physician Signature and ID # Date