THERAPY SERVICES
OUTPATIENT REFERRAL

MASONIC HOMES 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-10 DX Code: _____ Number of treatments per week: _____ for _____ weeks

Goals:

☐ Relief of pain ☐ Improve function ☐ Improve communicaiton

☐ 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 and repositioning ☐
- Neuromuscular re-education ☐
- Fine motor coordination ☐
- Sensory integration ☐
- Modalities ☐

Speech Therapy

- Oral motor therapy ☐
- Expressive/receptive Language therapy ☐
- VitalStim ☐
- Cognitive therapy ☐
- Augmentature and alternative communication Evaluation and 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: _____