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
☐ Decrease edema
☐ Increase dynamic balance
☐ Improve function
☐ Improve strength
☐ Increase ROM
☐ Improve communicaiton
☐ Improve swallowing

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)
☐ Other: _____

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: _____