



THUMB REGION

1100 S. Van Dyke • Bad Axe, Michigan 48413
Phone: (989) 269-1540 • Fax: (989) 269-2658 • www.mclaren.org/thumbregion

REHABILITATION SERVICES OUTPATIENT REFERRAL

Patient Name: _____ Date of Birth: _____

Diagnosis: _____

Precautions/Comments: _____

Your therapy evaluation is schedule for: Date: _____ Time: _____

PLEASE ARRIVE 15 MINUTES BEFORE YOUR APPOINTMENT TO GO THROUGH CENTRAL REGISTRATION. Please check with your insurance company for therapy coverage. Notify the therapy office if any prior authorization is needed. If you have questions please call 989-269-1540.

PHYSICAL THERAPY
Evaluation and Treatment
Gait training, Wt Bearing status
Therapeutic exercise/activities
Neuromuscular re-education
Manual therapy techniques
Balance/vestibular training
Instruct in Body Mechanics/Ergonomic instruction
Orthotics/Prosthetic training
Women's Health/Pelvic Floor Posture work
Other

OCCUPATIONAL THERAPY
Evaluation and Treatment
ADL training
Cognitive/Perceptual training
Therapeutic exercise/Activities
Neuromuscular reeducation
Manual therapy techniques
Orthotics/Prosthetic training
Splinting - Dynamic
Static
Functional capacity evaluation
Work conditioning/hardening
Other

MODALITIES: (AS NEEDED)
Ultrasound/phonophoresis
Electrical stimulation/TENS
Iontophoresis w/
Moist heat/ice
Traction: Cervical/lumbar
Manual Mechanical
Biofeedback

SPEECH THERAPY
Evaluation & Treatment
Aphasia/Language
Oral/Swallow function/Dysphagia
Modified Barium Swallow radiograph/Clinical Evaluation
Cognitive Skills
Sensory Integrative Techniques
Speech fluency
Hearing/Audiogram screening
Electronic augmentative device
Voice deficit
Other

Frequency: _____ times per week Duration: _____ weeks
Physician signature: _____ Date: _____
Physician's Name (printed) _____