MASONIC HOMES KENTUCKY

THERAPY SERVICES OUTPATIENT REFERRAL

Please select a location for services.
☐ Louisville Rehab Center / 3503 Moyers Circle / Phone 502.753.8850 / Fax 502.259.5290
☐ Shelbyville Rehab Center / 711 Frankfort Road / Phone 502.513.1875 / Fax 502.633.0661

NAME _____ DATE _____

DIAGNOSIS _____

ICD-10 DX CODE _____ NUMBER OF TREATMENTS PER WEEK _____ NUMBER OF WEEKS _____

REFERRING PHYSICIAN _____

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

CONTRAINDICATIONS / PRECAUTIONS / SPECIAL INSTRUCTIONS _____

WEIGHT BEARING STATUS _____ LEFT _____ RIGHT _____

PHYSICIAN'S 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 (Check all that apply.)
☐ Therapeutic exercises ☐ Strengthening ☐ Gait training ☐ Ultrasound ☐ Paraffin ☐ TENS
☐ Phonophoresis ☐ Manual therapy ☐ Balance retraining ☐ Iontophoresis ☐ Transfer skills
☐ Postural exercise ☐ Home exercise program ☐ Other _____

Occupational Therapy (Check all that apply.)
☐ 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 ☐ Modalities
☐ Other _____

Speech Therapy (Check all that apply.)
☐ Oral motor therapy ☐ Expressive/Receptive language therapy ☐ VitalStim ☐ Cognitive therapy
☐ Augmentative 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'S SIGNATURE _____ DATE _____

ID NUMBER _____

INITIAL