

PULASKI MEMORIAL HOSPITAL REHABILITATION PRESCRIPTION

Name: _____ Phone: _____

Diagnosis: _____ ICD-9: _____

Area Treated: _____

Special Instructions or Precautions: _____

- PHYSICAL THERAPY** **OCCUPATIONAL THERAPY** **SPEECH THERAPY**
- Evaluate and Treat Evaluate and Treat Evaluate and Treat
- * indicates OT only intervention Speech/Language
- Swallowing
- Modified Barium Swallow

Therapeutic Exercise

- Range of Motion PROM/AAROM/AROM
- Resistance Exercise
- Isometric Exercise
- Stretching/Flexibility Exercise
- Home Exercise Program

Manual Therapy

- Joint Mobilization
- Soft Tissue Mobilization
- Massage
- Scar Management/Desensitization
- Edema Control

Modalities

- Moist Heat/Cryotherapy
- Whirlpool
- Ultrasound/Phonophoresis
- Iontophoresis
- Electrical Stimulation/TENS
- Paraffin
- Traction Cervical/Pelvic

Equipment & Devices

- Lumbo-Sacral Support
- Ankle-Foot Orthosis
- Splint */Brace
Type: _____
- Foot Orthotic
- Compression Stockings
- Assistive Device Type: _____

Functional Training & Assessment

- Gait Training
- ADL Training *
- Cognitive Assessment *
- Home Safety Assessment *
- Task Modification
- Balance/Neuro Re-education

Programs

- Body Mechanics/Back Care
- Lumbar Stabilization
- Postural Exercises
- Work Hardening
- Hand Therapy *

Wound Management

- Debridement of Devitalized Tissue Whirlpool
- Compression Therapy
- Negative Pressure Wound Therapy

Frequency: 5x/wk 3x/wk 2x/wk Other: _____ **Duration:** _____ week(s)
 Therapist's Discretion

I hereby certify this treatment to be medically necessary.

Physician's Signature: _____ Date: _____

REHABILITATION PRESCRIPTION



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Form MM-820C Rev. 12/07

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