Your Hospital's Logo Here

REHABILITATIVE SERVICES CLARIFICATION

PHYSICIAN'S ORDER SHEET

ALL ORDERS WILL BE FULFILLED UNLESS CROSSED OUT

PATIENT IDENTIFICATION

Check (√) Each Order As Transcribed	
	Allergy:
	DATE: **TIME:** (Military Time)
	Physician's Name:
	Diagnosis:
	Discipline Requested: ☐ OT ☐ PT ☐ ST
	Modalities and / or Procedures prescribed for patient
	Occupational Therapy: **Frequency:** _____ ☐ Evaluation ☐ ADL Assessment/Treatment ☐ Therapeutic Exercises ☐ Modalities ☐ Adaptive Equipment ☐ Energy Conservation ☐ Splinting ☐ Other: _____ Therapist Signature: _____
	Physical Therapy: **Frequency:** _____ ☐ Evaluation ☐ Gait Training ☐ Therapeutic Exercises ☐ Modalities ☐ Cane / Crutches / Walker ☐ Mechanical Traction ☐ Wound Care ☐ Prosthetic / Orthotic ☐ Other: _____ Therapist Signature: _____
	Speech & Language / Swallowing: **Frequency:** _____ ☐ Evaluation ☐ Expressive Language ☐ Receptive Language ☐ Dysphagia ☐ Right Hemisphere Communication ☐ Cognitive Linguistic ☐ Motor Speech ☐ Swallow Function Study ☐ Speaking Valve ☐ Other _____ ☐ Home Program for Discharge Therapist Signature: _____
	Precautions / Special Instructions:
	PHYSICIAN CERTIFICATION It is my professional opinion that the treatment prescribed above is appropriate and medically necessary for the patient. Date: _____ Time: _____ (Military Time) Physician's Name (printed): _____

FAXED BY/TIME:

TIME NOTED:

Doctor's Signature _____,MD Date _____

Nurse's Signature / Title _____

Military Time > >

USE BALL POINT PEN ONLY - PRESS FIRMLY

PART OF THE MEDICAL RECORD