REHABILITATIVE SERVICES CLARIFICATION

PHYSICIAN'S ORDER SHEET

ALL ORDERS WILL BE FULFILLED UNLESS CROSSED OUT

Discipline Requested:  □ OT  □ PT  □ ST

Modalities and / or Procedures prescribed for patient

Occupational Therapy:
- Evaluation
- Modalities
- Splinting
- Other:
- Therapist Signature:

Physical Therapy:
- Evaluation
- Modalities
- Wound Care
- Other:
- Therapist Signature:

Speech & Language / Swallowing:
- Evaluation
- Dysphagia
- Motor Speech
- Speaking Valve
- Other:
- Therapist Signature:

Precautions / Special Instructions:

P H Y S I C I A N  C E R T I F I C A T I O N

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): ____________________

Doctor's Signature ____________________, MD  Date __________

Nurse's Signature / Title ____________________

FAXED BY/TIME: TIME NOTED: ____________________

Military Time > >