Physical
Rehabilitation
Services
OF MARLETTE REGIONAL HOSPITAL

2770 Main Street • Marlette, MI 48453
Phone (989) 635-4350 • Fax (989) 635-4358

Patient Name: _____

Diagnosis: _____

Frequency: _____ times a week for _____ weeks

☐ **PHYSICAL THERAPY** ☐ **OCCUPATIONAL THERAPY** ☐ **SPEECH THERAPY**

☐ **EVALUATE PATIENT, ESTABLISH AND IMPLEMENT PLAN OF CARE**

☐ THERAPEUTIC EXERCISE/ACTIVITES
☐ MANUAL THERAPY
☐ NEURO MUSCULAR RE-EDUCATION
☐ GAIT TRAINING
☐ AQUA THERAPY
☐ THERAPEUTIC MODALITIES

PRECAUTIONS: _____

_____

SPECIAL INSTRUCTIONS: _____

_____

Please ensure the following areas are complete:
Patient Name, Diagnosis, Frequency/Duration, Type of Therapy ordered and valid physician signature (rubber stamp not acceptable). Initiation of therapy services will begin after physician signs off on established plan of care or checks "Evaluate patient, establish and implement plan of care" box above.

I have examined the patient and certify the need for these services furnished under this plan of care effective and necessary. The patient will remain under my care and the above plan of care established will be reviewed minimally every 30 days.

_____ _____
Physician's Signature Date

Form #4185 (chg 9-14)