



# Neurologic Therapies

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Name: \_\_\_\_\_ Phone: \_\_\_\_\_ DOB: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Precautions: \_\_\_\_\_

## Physical Therapy

Impairment \_\_\_\_\_

ICD-9 Code: \_\_\_\_\_

- Evaluation and Treatment
  - \_\_\_ ROM/Stretching
  - \_\_\_ Strength Training
  - \_\_\_ Functional Mobility Training
  - \_\_\_ Balance Training
  - \_\_\_ Gait Training
  - \_\_\_ Other

### Specialty Programs

- PT Evaluation for Wheelchair/ Seating Assessment
- Amputee and Orthotics Clinic
- Balance Assessment including Smart Balance Master Evaluation
- Vestibular Rehabilitation
- Fall Risk Reduction Program
- CORE (Cognitive O/P Rehabilitation and Evaluation)

Other: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Frequency: \_\_\_\_\_ times per week  
for \_\_\_\_\_ weeks or \_\_\_\_\_ visits.

## Occupational Therapy

Impairment \_\_\_\_\_

ICD-9 Code: \_\_\_\_\_

- Evaluation and Treatment
  - \_\_\_ Activities of Daily Living (ADL)
    - Bathing, Dressing, and Feeding
  - \_\_\_ Instrumental ADL (IADL)
    - Community Reintegration and Mobility (driving skills)
    - Household and Financial Management
  - \_\_\_ Therapeutic Exercises and Activities
  - \_\_\_ Splint Fabrication and Training
  - \_\_\_ Adaptive Equipment Recommendations and Usage
- Training
  - \_\_\_ Neuromuscular Upper Extremity Facilitation

### Specialty Programs

- Clinical Driver Evaluation (eval only)
- CORE (Cognitive O/P Rehabilitation and Evaluation)

Other: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Frequency: \_\_\_\_\_ times per week  
for \_\_\_\_\_ weeks or \_\_\_\_\_ visits.

## Speech-Language Pathology

Impairment \_\_\_\_\_

ICD-9 Code: \_\_\_\_\_

- Evaluation and Treatment
  - \_\_\_ Cognitive/Linguistic
  - \_\_\_ Language
  - \_\_\_ Voice
  - \_\_\_ Augmentative/Alternative Communication
  - \_\_\_ Clinical Swallowing Evaluation
  - \_\_\_ Modified Barium Swallow, if indicated
  - \_\_\_ Dysphagia Treatment
  - \_\_\_ Other

### Specialty Programs

- CORE (Cognitive O/P Rehabilitation and Evaluation)

Other: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Frequency: \_\_\_\_\_ times per week  
for \_\_\_\_\_ weeks or \_\_\_\_\_ visits.

Physician signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician (Print): \_\_\_\_\_

Send progress note before next appointment on: \_\_\_\_\_