PHYSICIAN CLARIFICATION ORDER

Patient Name: ____________________________________________ Location: ________________________________

Physician: ______________________________________________ Date: ________________________________

Rehab Treatment Diagnosis: ________________________________ Type of Skilled Service: OT ☐ PT ☐ ST ☐

Type of Order: Clarification of Treatment/Plan of Care ☐ Frequency/Duration: ________________________________

Discharge ☐ Other ☐

Plan of Care:
☐ Gait training ☐ Strengthening ☐ Home Assessment/Modifications
☐ Functional Transfer Training ☐ Joint Mobility ☐ Bed Mobility
☐ Ultrasound (See Specific Instruction) ☐ Hot/Cold Applications ☐ Feeding
    For details ☐ Paraffin ☐ Self Care/Management
☐ E. Stim (See Specific Instruction) ☐ CPM ☐ Community Re-Integration
☐ Task Analysis ☐ Massage ☐ Cognitive Skills Development
☐ Energy Conservation Tech ☐ Edema Control ☐ Dysphagia
☐ Safety ☐ CPM ☐ Speech Language
☐ Functional Mobility ☐ Adaptive Equip/DME Training ☐ Compensatory Swallowing Tech.
☐ Balance/Coordination Activities ☐ W/C Management/Mobility ☐ Oral Laryngeal Exercises
☐ Gross/Fine Motor Coordination ☐ W/C and/or Seating Assessment ☐ Functional Compensatory Tech.
☐ Neuromuscular Re-Education ☐ ADL Training ☐ Modified Barium Swallow
☐ Range of Motion ☐ Independent ADL’s ☐ Home Exercise Program
☐ Sensory Stimulation ☐ Splinting ☐ Patient/Caregiver Training
☐ Mobility/Stretching ☐ Low Vision ☐ D/C Planning
☐ Orthotic/Prosthetic Fabrication ☐ Posture ☐ OTHER (see Specific Instructions
☐ Orthotic/Prosthetic Fit/Train ☐ Endurance For details

Physician Specific Instructions:

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Physician Signature: ____________________________________________ Date: ________________________________