

Patient Name:

Patient DOB:



University Health System

Reeves Rehabilitation Center

PHYSICAL THERAPY

SPECIAL PROGRAM: PHYSICIAN ORDER SHEET

PHONE: (210)358-2710 FAX: (210)358-4739

TREATMENT LOCATION: Medical Center Pavilion

MEDICAL DIAGNOSIS:  Gait Ataxia  FACIAL NERVE INJURY  Other \_\_\_\_\_

TYPE OF SURGERY: \_\_\_\_\_

LANGUAGE:  SPANISH ONLY  OTHER: \_\_\_\_\_

PRECAUTIONS:  NONE

MEDICAL PRECAUTIONS:  SEIZURES  CARDIAC (60<Heart Rate<120, Systolic BP<200, Diastolic BP<100)

OTHER PRECAUTIONS: \_\_\_\_\_

OTHER INSTRUCTIONS: \_\_\_\_\_

PHYSICAL THERAPY VESTIBULAR PROGRAM

Evaluation

TREATMENT:

- Per Therapist
- Epley Maneuver
- Modalities
- Other (describe below)

FREQUENCY/DURATION

- Frequency/Duration per therapist
- Daily
- Biweekly } **for 6 – 8 weeks**
- Three times a week
- Other duration: \_\_\_\_\_

PHYSICAL THERAPY FACIAL NERVE PROGRAM

Evaluation

TREATMENT:

- Per Therapist
- Therapeutic Exercises
- Neuromuscular Rehabilitation
- Modalities
- Therapeutic Activities
- Other (describe below)

FREQUENCY/DURATION

- 5 visits in 12 months
- Frequency/Duration per therapist
- Other duration: \_\_\_\_\_

REQUESTING PHYSICIAN (PRINT): \_\_\_\_\_ DATE/TIME: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ ID#: \_\_\_\_\_

PHYSICIAN PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_