



RehabCentral  
1500 Koenigstein Avenue  
Norfolk, NE 68701  
www.frhs.org

402-644-7396  
FAX 402-644-7394

## Physical and Occupational Therapy Consultations

Please contact your insurance company to verify coverage.

Patient Name: \_\_\_\_\_

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

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

Frequency of Treatment \_\_\_\_\_ days/week for \_\_\_\_\_ weeks

Certification / Recertification from \_\_\_\_\_ to \_\_\_\_\_

\*Check all boxes that apply.

**PHYSICAL THERAPY**

**OCCUPATIONAL THERAPY**

**Evaluation and Treatment**

Therapeutic Exercise

Home Exercise Program

Manual/Mobilization Techniques

Modalities as Indicated

Iontophoresis with dexamethazone

Phonophoresis with 10% hydrocortizone cream

Biofeedback

Gait Training: weight bearing status: \_\_\_\_\_

Functional Capacity Evaluation

Work hardening/Conditioning

Aquatic Therapy/Pool

Wheelchair Evaluation

Vision Therapy

Athletic Training Consultation

Other \_\_\_\_\_

Orthotics/Splint type: Please specify \_\_\_\_\_

Special Instructions: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

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

Duration of Treatment \_\_\_\_\_ weeks

Frequency of Treatment 1 2 3 4 5 days/week

### Speech/Language Pathology

- |   |   |
|---|---|
| <input type="checkbox"/> Speech/Language Evaluation                         | <input type="checkbox"/> Speech/Language Therapy        |
| <input type="checkbox"/> Clinical Swallowing Evaluation                     | <input type="checkbox"/> Dysphagia (Swallowing) Therapy |
| <input type="checkbox"/> Modified Barium Swallow<br>(oral/pharyngeal phase) | <input type="checkbox"/> Other _____                    |

Special Instructions: \_\_\_\_\_

Physician Signature: \_\_\_\_\_