

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD-10 Code: \_\_\_\_\_

Comments / Precautions: \_\_\_\_\_

**The Balance Center**

15 Sunburst Center  
Cambridge, MD 21613  
Tel: 410-221-0029  
Fax: 410-221-2984

**Shore Rehabilitation at Cambridge**

15 Sunburst Center  
Cambridge, MD 21613  
Tel: 410-221-0029  
Fax: 410-221-2984

**Shore Rehabilitation at Denton**

1140 Blades Farm Rd. Suite 201  
Denton, MD 21629  
Tel: 410-479-3300  
Fax: 410-479-3382

**Shore Rehabilitation at Easton**

10-B Martin Court  
Easton, MD 21601  
Tel: 410-822-3080  
Fax: 410-820-0003

**Shore Rehab at Queenstown**

125 Shoreway Dr. Suite 280  
Queenstown, MD 21658  
Tel: 410-827-3818  
Fax: 410-827-7635

**PHYSICAL THERAPY**

- Evaluation / Treatment
- Therapist's Discretion
- Ultrasound
- Phonophoresis
- Iontophoresis
- Electrical Stimulation
- Manual Therapy
- Other \_\_\_\_\_

**EXERCISE**

- Active
- Passive
- Active / Assistive
- Resistive
- Stretching

**GAIT TRAINING**

- Weight Bearing as Tolerated
- Partial Weight Bearing
- Non-Weight Bearing
- Other \_\_\_\_\_

**PT PROGRAMS**

- Balance / Vestibular
- Bertec Balance Test
- Lokomat
- Parkinson's

**OCCUPATIONAL THERAPY**

- Evaluation / Treatment
- Therapist's Discretion
- Activities of Daily Living
- Joint Protection
- Energy Conservation
- De-sensitization Program
- Sensory Re-education
- Splinting
- Perceptual / Sensory Training
- Coordination Gross / Fine Motor
- Hand Therapy
- Lymphedema
- Other \_\_\_\_\_

**EXERCISE**

- Active
- Passive
- Active / Assistive
- Resistive
- Stretching

**SPEECH-LANGUAGE PATHOLOGY**

- Speech-Language Evaluation / Treatment
- Therapist's Discretion
- Dysphagia (Swallowing) Evaluation / Treatment
- Video Fluoroscopic Swallowing Evaluation
- Cognitive Evaluation / Treatment
- Other \_\_\_\_\_

Progress: \_\_\_\_\_

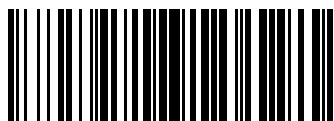
New Goals: \_\_\_\_\_

Plan: \_\_\_\_\_

Treatment: Frequency: \_\_\_\_\_ / Duration: \_\_\_\_\_ Therapist Signature: \_\_\_\_\_

The Therapist signed above will be responsible for administering or directly supervising the treatment or evaluation as planned above in consultation with the referring practitioner. He / She is qualified in accordance with Federal Regulations and is currently licensed to practice in the State of Maryland. **Rehabilitation Services outlined above are necessary for the Rehabilitation of this patient and the plan will be reviewed by me.**

PHYSICIAN NAME: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_ DATE/TIME: \_\_\_\_\_



CIM.145243

**REFERRAL / PLAN OF CARE FOR REHABILITATION SERVICES**

