



\*PHYSORDER\*

# Outpatient Physical and Occupational Therapy Order Form

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Form Origination Date: 7/06  
Version: 2

Version Date: 8/08

This form may be completed on line. Tab or move  
cursor to text field and type in text.

For HIPAA Compliance reasons, this form  
IS NOT TO BE SAVED with patient information.  
Selecting the PRINT button will clear all information  
from the note.

Patient Name \_\_\_\_\_  
MRN \_\_\_\_\_  
PATIENT IDENTIFICATION LABEL

Physical Therapy Referral     Occupational Therapy Referral     Hand Rehab Referral

**Downtown: Main Hospital**

MUSC Medical Center  
169 Ashley Avenue  
Bldg 3SW  
Charleston, SC 29425  
Ph: (843) 792-3481  
Fax: (843) 792-0724

**Downtown: Ashley Avenue**

MUSC Medical Center  
158 Ashley Ave  
Suite C102  
Charleston, SC 29425  
Ph: (843) 792-6366  
Fax: (843) 792-8665

**James Island**

MUSC Medical Plaza  
650 Ellis Oak Avenue  
Charleston, SC 29412  
Ph: (843) 266-1540  
Fax: (843) 266-1567

**West Ashley**

MUSC Medical Plaza  
2125 Charlie Hall Blvd.  
Charleston, SC 29414  
Ph: (843) 876-0909  
Fax: (843) 573-1511

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

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

Surgical Procedures: \_\_\_\_\_

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

Allergies: \_\_\_\_\_

Frequency: \_\_\_\_\_ Duration: \_\_\_\_\_

### Treatment Recommendations

- Evaluation and Treatment
- Therapeutic and Home Exercise Instruction
- Spine Rehabilitation
- Sports Rehabilitation
- Arthritis Program
- Aquatic Physical Therapy Program
- Fibromyalgia Program
- Lymphedema Management
- Neurological Rehabilitation
- Balance Rehabilitation
- Vestibular Rehabilitation
- Osteoporosis Management
- Pelvic Floor Rehabilitation
- Isokinetic Evaluation and Training
- Gait Training
- Pediatric Therapy Services (Main Hospital only)

- Biofeedback / Neuromuscular Re-Education
- Ultrasound
- Phonophoresis with fluocinonide
- Iontophoresis with dexamethasone
- Electrical Stimulation / TENS / NMES
- Mechanical Traction
- Functional Capacity Evaluation
- Work Conditioning Program
- Work Site / Ergonomic Analysis
- ADL Re-training
- Pre-Operative Education
- Hand Rehabilitation
- Splint Type: \_\_\_\_\_

Orthotic Fabrication: \_\_\_\_\_

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

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

Physician Name (Printed): \_\_\_\_\_ Attending MD: \_\_\_\_\_

Pager ID: \_\_\_\_\_ Fax: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Information:  BC/BS     Commercial     Companion     HMO Blue     Tricare     Medicare     Medicaid  
 Worker's Compensation     Other: \_\_\_\_\_

Policy #: \_\_\_\_\_ Authorization #: \_\_\_\_\_