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

UNIVERSITY of MARYLAND SHORE REGIONAL HEALTH

Form # 145243 (03/19)