

PHYSICIAN PLAN OF CARE - CHANGE AND ADDITIONAL ORDERS

Patient/Client Name: _____ Date: _____
 Patient/Client Address: _____
 Physician's Name: _____
 Physician's Phone: _____ Fax: _____
 County: _____

Dear Doctor:

The orders shown below are being forwarded for your signature to authorize your verbal orders given on this date. Please sign and return this form within three (3) days for our patient's chart. *Thank you for the referral of your patient for services.*

Initial Evaluation Routine Visit
 Frequency/Duration _____ AS OF Date ____ / ____ / ____

| | | |
|---|---|--|
| <p>ST Evaluation Date: ____ / ____ / ____ ST for: <input type="checkbox"/> Evaluation <input type="checkbox"/> Administer diagnostic tests: _____</p> | <p>Dysphagia Treatment ST to provide: <input type="checkbox"/> Instruct on safe swallowing techniques <input type="checkbox"/> Instruct on swallowing exercises <input type="checkbox"/> _____</p> | <p>Aural Rehab ST to: <input type="checkbox"/> Upgrade speech reading skills <input type="checkbox"/> Instruct manual communication <input type="checkbox"/> _____</p> |
| <p>Voice Disorder Treatment ST to instruct on: <input type="checkbox"/> Esophageal speech techniques <input type="checkbox"/> Exercises to improve voice quality <input type="checkbox"/> Exercises to improve voice production <input type="checkbox"/> _____</p> | <p>Language Disorders ST to provide and instruct on: <input type="checkbox"/> Word finding exercises <input type="checkbox"/> Exercises to improve oral-gestural language <input type="checkbox"/> Exercises to promote spontaneous speech <input type="checkbox"/> Exercises to facilitate reading comprehension <input type="checkbox"/> Exercises to improve written language <input type="checkbox"/> Exercises to improve memory <input type="checkbox"/> Exercises to improve orientation <input type="checkbox"/> _____</p> | <p>Non-Oral Communication <input type="checkbox"/> Establish a non-oral communication system <input type="checkbox"/> Develop augmentative communication system, <input type="checkbox"/> _____</p> |
| <p>Speech Articulation Disorder Treatments ST to provide instruction on: <input type="checkbox"/> Articulatory procedures <input type="checkbox"/> Exercises to improve oro-motor function <input type="checkbox"/> _____</p> | | <p>Other ST to: <input type="checkbox"/> Establish home exercise program <input type="checkbox"/> _____</p> |

GOALS: Rehab Potential: Good Fair

1. Patient will require _____ (level of assistance) with feeding within _____ weeks.
2. Patient will demonstrate improved perceptual function as evidenced by _____ within _____ weeks.
3. Patient will demonstrate improved receptive language functioning (understanding or oral/gestural language) within _____ weeks.
4. Patient will demonstrate improved expressive language functioning: word finding orientation elaboration of verbal responses communication of functional needs memory within _____ weeks.
5. Patient will demonstrate increased speech intelligibility to _____ % within _____ weeks.
6. Patient will demonstrate safe swallowing skills related to _____ within _____ weeks.
7. Patient/Caregiver will be independent in home exercise program within _____ weeks.
8. Patient/Caregiver will verbalize understanding of discharge plan within _____ days/weeks.
9. Other: _____

Therapist's Signature: _____ Date: ____ / ____ / ____

Physician's Signature: _____ Date: ____ / ____ / ____