St. Vincent's Special Needs Services
95 Merritt Blvd., Trumbull, Ct
203-386-2748 fax 203-386-2725

SERVICES NEEDED AFTER HOSPITALIZATION OR PROLONGED MEDICAL ABSENCE

To: _____
Physician

_____ will be returning to SVSNS after hospitalization or a prolonged medical absence. In order to ensure optimum care we are requesting the following information:

Date of hospitalization/treatment: _____

Reason for hospitalization/medical absence: _____

Are there limitations to program hours or days of service? _____

Are there special transportation precautions? _____

Is there a potentially infectious condition staff should be aware of? _____

_____

Are there special recommendations or limitations fro physical, speech and/or occupational therapy or other program services?

_____

_____

PLEASE ATTACH ANY SPECIFIC THERAPY ORDERS

Are there special recommendations or limitations for diet, or other activities? _____

_____

Are there changes in medication? _____

_____

Is there any other pertinent information which SVSNS staff should be aware of? _____

_____

_____

Who should we contact if we have any questions or concerns? _____

_____

_____ _____
Signature of Physician Date

**** PLEASE ATTACH ANY PHYSICAL THERAPY ORDERS****

PHYSICAL THERAPY ORDERS

Name: _____ DOB: _____

Diagnosis: _____

Please check one of the following:

□ Resume PT with no restrictions

□ Resume PT with the following restrictions:

_____
_____
_____
_____

□ Hold PT

Recommendations for follow-up:

_____
_____
_____
_____

_____ _____
Signature of Physician Date

_____
Phone/Contact number