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 for 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