

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: \_\_\_\_ / \_\_\_\_ / \_\_\_\_