Saint Francis Healthcare
Sports Medicine & Rehabilitation Centers

Physical Therapy/Occupational Therapy/Speech Therapy Orders

__Memphis
5959 Park Avenue
(within Saint Francis Hospital)
Memphis, TN 38119
Phone 901-765-2230
Fax 901-765-2253

__Collierville
1185 Schilling Blvd., E
(within the YMCA)
Collierville, TN 38017
Phone 901-854-5010
Fax 901-854-0670

__Olive Branch
8555 Goodman Rd.
(within the YMCA)
Olive Branch, MS 38654
Phone 662-895-2332
Fax 662-895-2360

__Bartlett
8025 Hwy 64, Suite 102
Memphis, TN 38133
Phone 901-382-6280
Fax 901-382-6286

__Millington
7725 Navy Circle East
(within the YMCA)
Millington, TN 38053
Phone 901-873-1591
Fax 901-873-1597

PATIENT NAME: _____ **PATIENT'S DATE OF BIRTH:** _____

PATIENT'S HOME PHONE: _____ **PATIENT'S WORK PHONE:** _____

CURRENT PROBLEMS/SYMPTOMS/DIAGNOSIS **ICD-10 CODE**

_____ _____

_____ _____

_____ _____

RECENT SURGICAL PROCEDURE/DATE OF SURGERY: _____

THERAPY REQUESTED **___Physical Therapy** **___Occupational Therapy** **___Speech Therapy**

___ Shoulder Rehab
___ Knee Rehab
___ Ankle Rehab
___ Hip Rehab
___ Back Rehab
___ Neurological Rehab
___ Aquatic Therapy (Collierville/Millington/Olive Branch)
___ Wound Care (Memphis & Bartlett)
___ KT 1000 Test
___ Orthotic Fabrication/Training
___ Work Conditioning
___ Lymphedema Rehab (Memphis/Bartlett/Millington)
___ Pediatric Programs
___Elbow/Wrist/Hand Rehab
___Splinting
___ADL Assessment/Training
___Speech/Language Rehab
___Adult___Fluency Eval/Rehab
___Dysphagia Evaluation./Rehab

___ Modalities as Indicated or Check:
___ Ultrasound ___ Traction ___ Paraffin
___ Electrical Stimulation ___ Iontophoresis
___ Hot Pack ___ Cold Pack

Other: _____

FREQUENCY AND DURATION _____ **X per WEEK FOR** _____ **WEEKS**

I certify that the above plan of care is appropriate and necessary.

PHYSICIAN'S SIGNATURE: _____ **DATE:** _____

Physician's UPIN#_____ Physician's Fax #_____ Physician's Phone #_____