

Patient Name: _____ Date: _____

Diagnosis: _____

Precautions: Post-polio syndrome - do not over-fatigue _____

Recommended facility: _____ Call 713-797-5942 for appt. for TIRR/MHHS _____

PHYSICAL THERAPY: (___ visits per week for ___ weeks)

Evaluate and treat with emphasis on:

- Pain management
- Myofascial/manual techniques, as indicated
- Modalities, as indicated
- Low intensity ther ex, may include water exercise
- Relaxation ex
- Stretching, PROM
- Aquatic exercise
- Home program, to include energy conservation
- Home safety eval
- Other: _____

- Gait training with new _____
- Balance training
- Functional training

Precautions:

- Do not exercise with added resistance other than body weight or pool water
- Start patient at 50% intensity and twice as much rest as patient with no polio history. Increase/decrease from there.

OCCUPATIONAL THERAPY: (___ visits per week for ___ weeks)

Evaluate and treat with emphasis on:

- Pain management
- Myofascial/manual techniques, as indicated
- Modalities, as indicated
- Low intensity ther ex, may include water exercise
- Relaxation ex
- Stretching, PROM
- Home program, to include energy conservation
- Home safety eval
- Other: _____

- ADL with energy conservation strategies
- Splint fabrication and/or fitting
- Functional training

Precautions:

- Do not exercise with added resistance other than body weight or pool water
- Start patient at 50% intensity and twice as much rest as patient with no polio history. Increase/decrease from there.

WHEELCHAIR CLINIC (PT OR OT):

- Evaluation and prescription for mobility device
- Seating and positioning evaluation and prescription
- Pressure mapping and cushion prescription

Special seating concerns include: _____

SPEECH PATHOLOGY: (___ visits per week for ___ weeks)

Evaluate and treat with emphasis on:

- Modified barium swallow
- Energy conservation strategies
- Other: _____

- Treatment for dysphagia
- Treatment for voice disorder

NUTRITION/DIETARY:

Evaluate and treat with emphasis on:

- Weight loss
- Diabetic and/or heart healthy diets
- Other: _____

Referring physician from TIRR Post-Polio Out-Patient Clinic:

Signature _____ Physician Print Name _____ NPI/MHHS ID. _____ Date _____ Time AM PM Contact No. _____

For questions, please contact Carolyn Da Silva, PT DSc, NCS at 713-794-2087.

MEMORIAL
HERMANN

Prescription for Therapy: Post-Polio
Out-Patient Clinic

OUT-PATIENT AND HOME HEALTH

