DMC
Rehabilitation Institute of Michigan

COVID-19 REHAB RECOVERY PROGRAM OUTPATIENT THERAPY SCREENING/PRESCRIPTION

	NO	YES
1. Do you have shortness of breath and/or weakness that limits your ability to complete daily activities?	☐	☐
2. Do you have shortness of breath and/or weakness that limits your ability to complete household chores?	☐	☐
3. Do you have shortness of breath and/or weakness that limits your ability to participate in community activities?	☐	☐
4. Does your shortness of breath and/or weakness force you to use a walking aid that you have not used before?	☐	☐
5. Does your shortness of breath require you to use supplemental oxygen?	☐	☐

PHYSICAL THERAPY PRESCRIPTION (For an appointment near you, call **313-745-1100**)

Patient Name: ____________________

Diagnosis: __Generalized weakness due to COVID-19 (M26.81) __ Difficulty walking due to COVID-19 (R26.2)

__Malaise, debility, decline in functional status due to COVID-19 (R53.81)

Precautions: ____________________

Ordering any of the programs may include some or all of the treatment options listed below.

___ Breathing exercise ___ Strengthening ___ Aerobic exercise

___ Flexibility/stretching ___ Home program instruction

Special instructions for patients requiring supplemental oxygen: ___ May titrate 02 to maintain >90% saturation ___ May NOT titrate 02

Frequency: ______ x per week Duration: ________ weeks

Physician's Signature ____________ Date ____________ Physician's Phone/Pager ____________

I certify that I have examined the patient and physical therapy is necessary and the services will be furnished while the patient is under my care and that the plan is established and will be reviewed every 30 days or more often, if the patient's condition requires.

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