PATIENT INSTRUCTIONS: PLEASE PRINT OUT, COMPLETE FORM, AND BRING TO YOUR APPOINTMENT.

Outpatient Rehabilitation and Sports Medicine
Attendance Policy

Contact Number: (843) 777-2196
Hours of operation: Monday - Thursday 7 am -7 pm and Friday 7 am - 4 pm

Thank you for selecting McLeod Rehab and Sports Medicine Services to provide you therapy. We ask that you adhere to the following policies to assure both you and your physician will receive the maximum benefit from your therapy.

1. ATTENDANCE: Please attend each of your scheduled appointments as you may not benefit from therapy if you miss your scheduled treatments. If you must miss your appointment, please call the clinic 24 hours prior to your appointment time to allow for rescheduling.
You will be discharged from therapy if you:

- Cancel 3 appointments
- Do not show for scheduled appointments 2 times without calling

If you are discharged from therapy, you will be responsible to obtain a new prescription from your doctor before you can be re-evaluated and scheduled for further appointments.

2. ARRIVAL TIME: Please arrive on time for your scheduled appointment. If you are late, we cannot guarantee that your therapist will be able to spend your full treatment time with you. A phone call may allow us to reschedule your appointment.

3. CANCELLATIONS: If you are seeing more than 1 therapist (PT, OT, ST) please indicate this when calling the clinic to cancel or reschedule an appointment.

4. NEW ORDERS: New orders for continued therapy are necessary if you are admitted to a hospital or have a new or serious injury.

5. SAFETY: Due to safety reasons and space restrictions, we request that you not bring family or friends into the treatment gym/rooms unless requested by your therapist. Children under 16 may not be left unattended in the waiting area.

_____	_____	_____	_____
Patient name (print)	Date of Birth	Date	Time

_____	_____
Patient Signature	Witness (McLeod Employee)

Created: 01/2018

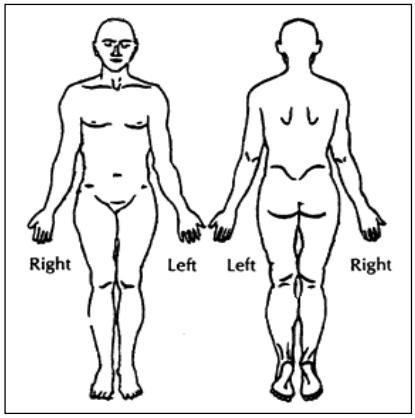
Outpatient Rehabilitation and Sports Medicine Intake Form

Name: _____ Date of Birth: _____
Home Phone # _____ Work/Cell # _____
Is there any other person we can speak with about your appointments? _____
May we leave information about your appointments on your answering machine? YES or NO
Are you currently receiving any Home Health Services? YES or NO
Education: Highest grade completed? _____
Learning Preference: Read Listen Demonstration Other_____

Pain:
Choose a number from 0 to 10 that best describes your pain (0 = no pain, 10 = unbearable pain)

0	1	2	3	4	5	6	7	8	9	10

Shade in areas of symptoms/pain below:



What makes your pain better? _____

What makes your pain worse? _____

Past Medical History/Surgeries:

_____

_____

Do you have difficulty with any of the following:

Balance Trouble moving around Feeling you might trip or fall Walking Getting in/out of bed, a chair, the car Muscle weakness Pain in your legs, back, or neck Location:_____	Tiredness/lack of energy Trouble concentrating, thinking, or remembering things Lifting things, even just your arms Taking care of yourself (dressing or bathing) Daily tasks like chores, or shopping Returning to work or completing tasks at work Pain in your arms or hands. Location:_____	Speaking Swallowing Other difficulty: _____

McLeod Health

The Choice for Medical Excellence

Place Patient Label Here

MCLEOD OUTPATIENT REHAB AND SPORTS MEDICINE MEDICATION FORM

Patient Name: _____ Patient Birth Date:_____

LIST ALL CURRENT ALLERGIES BELOW:

Allergic To:	Reaction

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: prescription and over-the-counter medications. Include medications taken as needed.

DATE	NAME OF MEDICATION / DOSE	DIRECTIONS (patient friendly)	Notes: Reason for taking/ Doctor Name

Created: 06/2018