NEW JERSEY INSTITUTE FOR DISABILITIES
LAKEVIEW SCHOOL
10 OAK DRIVE
EDISON, NJ 08837
732-549-5580 x2600 Fax: 732-590-2426

ER Visit/POST HOSPITALIZATION/SURGERY THERAPY

Student Name: _____ Date of Birth:_____

Name of Hospital: _____

Reason for ER Visit/Hospitalization: _____

Admission Date: _____ Discharge Date: _____

Surgical/Medical Procedure/Intervention:

_____

MAY RETURN TO SCHOOL ON: _____

Resume Physical Therapy: Yes____ No____

Weight bearing: none__ partial__ full__ as tolerated ___

Use of Mechanical Lift if needed: Yes____ No____

Resume Gym/Adaptive PE: Yes___ No____
Resume Aquatic Therapy: Yes _____ No____

Contraindications/Restrictions/Specifics:

_____
_____
_____

Resume Occupational therapy: Yes____ No____

Contraindications/Restrictions:

_____
_____

Resume Speech Therapy: Yes____ No____

Contraindications/Restrictions:

_____
_____

Alternate Positioning/Adaptive Equipment:
All Positions as Tolerated: Yes____ No____

Side-lyer: Yes____ No____

Sitting: Yes____ No____ Angle of seat:_____

Leg Positioning: Elevated: Yes____ No____ Degree of elevation: _____

Abduction Wedge: Yes____ No____ Frequency of Use: _____

AFO's: _____ SWASH: _____ Splints _____

Other: _____

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ER Visit/POST HOSPITALIZATION/SURGERY NURSING

Student Name: _____ Date of Birth: _____

Surgical/Medical procedure performed: _____ Date: _____
(or Reason for Hospitalization)

Admitting Diagnosis: _____

Discharge Diagnosis: _____

Medications:

Resume all previous medication orders: Yes _____ No _____

Medication Change/Addition: Yes ____ No _____

New Medications / Changes:

Name _____ Dose _____ Time_____ Route:_____
Name _____ Dose _____ Time_____ Route:_____
Name _____ Dose _____ Time_____ Route:_____
Name _____ Dose _____ Time_____ Route:_____

Dressings:

Description: _____
_____

Time: _____

Treatments:

Description: _____
_____

Time: _____

Diet:

Resume previous diet: Yes _____ No _____

Dietary changes: _____

Physician Signature: _____ Date: _____

Physician name and address (print/stamp): _____
_____