

### Outpatient Therapy Prescription Form

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Diagnosis : \_\_\_\_\_ Dx Code : \_\_\_\_\_

Surgical Procedure: \_\_\_\_\_ Onset Date: \_\_\_\_\_ Precautions: \_\_\_\_\_

**PHYSICAL THERAPY**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Evaluate and Treat                     | <input type="checkbox"/> Home Exercise Program             | <input type="checkbox"/> Lymphedema ( <i>Main campus</i> )       |
| <input type="checkbox"/> Aquatic Therapy ( <i>Main campus</i> ) | <input type="checkbox"/> FCE ( <i>Main campus</i> )        | <input type="checkbox"/> Foot Orthotics                          |
| <input type="checkbox"/> Gait Training                          | <input type="checkbox"/> ROM active passive                | <input type="checkbox"/> Strengthening/PRE's                     |
| <input type="checkbox"/> Spine Rehab                            | <input type="checkbox"/> Posture/Body Mechanics            | <input type="checkbox"/> Total Joint Rehab                       |
| <input type="checkbox"/> Vestibular/Balance Program             | <input type="checkbox"/> Pilates                           | <input type="checkbox"/> Wheelchair Eval ( <i>Main campus</i> )  |
| <input type="checkbox"/> Protocol _____                         | <input type="checkbox"/> Wound Care ( <i>Main campus</i> ) | <input type="checkbox"/> Pressure Mapping ( <i>Main campus</i> ) |
| <input type="checkbox"/> Modality of Choice _____               |  |  |
| <input type="checkbox"/> Other _____                            |  |  |

**OCCUPATIONAL THERAPY**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Evaluate and Treat       | <input type="checkbox"/> Home Exercise Program          | <input type="checkbox"/> Sensory Retraining |
| <input type="checkbox"/> ADLs                     | <input type="checkbox"/> Adaptive Equipment Training    | <input type="checkbox"/> ROM active passive |
| <input type="checkbox"/> Driver's Screen/Training | <input type="checkbox"/> Hand Therapy: elbow/wrist/hand | <input type="checkbox"/> Visual Perception  |
| <input type="checkbox"/> Splints static dynamic   | <input type="checkbox"/> Cognitive Retraining           |   |
| <input type="checkbox"/> Modality of Choice _____ |   |   |
| <input type="checkbox"/> Other _____              |   |   |

**SPEECH THERAPY**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Evaluate and Treat  | <input type="checkbox"/> Home Exercise Program       | <input type="checkbox"/> Dysphagia Therapy |
| <input type="checkbox"/> Speech/Language Therapy                                     | <input type="checkbox"/> Cognitive Therapy           |  |
| <input type="checkbox"/> Modified Barium Swallow                                     | <input type="checkbox"/> FEES ( <i>Main campus</i> ) |  |
| <input type="checkbox"/> Augmentative Alternative Communication Evaluation/Treatment |  |  |
| <input type="checkbox"/> Other _____   |  |  |

**FREQUENCY AND DURATION**

1 2 3 4 5 Times/Week for \_\_\_\_\_ Weeks

Referring Physician Signature \_\_\_\_\_ Phone # \_\_\_\_\_

Print Name \_\_\_\_\_ Fax # \_\_\_\_\_

*Prescription expires in 90 days*