Rehab Accomplished

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Maximizing Your Potential

Outpatient Therapy Prescription Form

Patient Name:_____ Date: _____

DOB: _____ Diagnosis:_____

Dx Code: _____

Surgical Process:_____ Onset Date: _____

Precautions: _____

☐ PHYSICAL THERAPY

- ☐ **Evaluate and Treat**
- ☐ Aquatic Therapy
- ☐ Gait Training
- ☐ Spine Rehab
- ☐ Vestibular/Balance Program
- ☐ Protocol _____
- ☐ Home Exercise Program
- ☐ FCE
- ☐ ROM Active/Passive
- ☐ Posture/Body Mechanics
- ☐ Pilates
- ☐ Wound Care
- ☐ Lymphedema
- ☐ Foot Orthotics
- ☐ Strengthening/PRE's
- ☐ Total Joint Rehab
- ☐ Wheelchair Eval
- ☐ Pressure Mapping
- ☐ Modality of Choice _____
- ☐ Other_____

☐ OCCUPATIONAL THERAPY

- ☐ **Evaluate and Treat**
- ☐ ADLs
- ☐ Driver's Screen Training
- ☐ Splints Static/Dynamic
- ☐ Home Exercise Program
- ☐ Adaptive Equipment Training
- ☐ Hand Therapy: elbow/writst/hand
- ☐ Cognitive Retraining
- ☐ Sensory Retraining
- ☐ ROM Active/Passive
- ☐ Visual Perception
- ☐ Modality of Choice _____
- ☐ Other_____

☐ SPEECH THERAPY

- ☐ **Evaluate and Treat**
- ☐ Speech/Language Therapy
- ☐ Modified Barium Swallow
- ☐ Home Exercise Program
- ☐ Cognitive Therapy
- ☐ FEES
- ☐ Dysphagia Therapy
- ☐ Augmentative Alternative Communication Evaluation/Treatment
- ☐ Other_____

FREQUENCY AND DURATION

1 2 3 4 5 Times Per Week for _____ Weeks

Physician Name (Print): _____

Date: _____ Physician Signature: _____

Phone: _____ Fax: _____

Prescription expires in 90 days

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