



ADAPTIVE COMMUNICATION & COMPUTER TECHNOLOGY OUTPATIENT PRESCRIPTION

3011 Baltimore Ave | Kansas City, MO 64108 | T: 816.751.7748 | F: 816.751.7984

Name: _____ Date of Birth: _____

Primary Diagnosis: _____

ICD-10 Code: _____ Social Security #: _____

Phone(H): _____ Phone (other): _____

THERAPY NEEDS:

- Checkboxes for L. Hemi, R. Hemi, Aphasia, Dysarthria, Non-Verbal, Coordination, Spasticity, Neglect, Weakness, Low Vision, Expressive/Receptive Language, Other.

Occupational Therapy

- Checkboxes for Evaluation, Functional Training, Self Care, Manual Therapy, Cognitive Treatment

Speech Pathology

- Checkboxes for AAC Evaluation, Speech, OT, Speech Language TX

Other: Includes evaluation and treatment for AAC (augmentative/alternative communication) methods and acquisition of equipment, tools or strategies that are identified through the evaluation/treatment process.

Goal(s): Maximize Home Function, Maximize Community Function, Other:

Frequency: _____ Times per week Duration: _____ Weeks

Precautions: _____ None

PLEASE PROVIDE THE FOLLOWING INFORMATION:

Physician Name: _____

Address: _____

Office Phone: _____ Office Fax: _____

Certification: Signature below certifies that during the course of treatment as outlined above in occupational or speech therapy that the patient will be under the care of the ordering physician.

M.D. or D.O's Signature ONLY* _____ Date: _____

*Our licensing regulations require that only M.D. or D.O can sign therapy orders.