ABILITY KC®

ADULT
OUTPATIENT PRESCRIPTION

3011 Baltimore Ave | Kansas City, MO 64108 | T: 816.751.7783 | F: 816.751.7984

Name: _____ Date of Birth: _____

Primary Diagnosis: _____

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

THERAPY NEEDS:

☐ L. Hemi ☐ R. Hemi ☐ Gait ☐ Balance ☐ Dysarthria ☐ Cognition
☐ Dysphagia ☐ Aphasia ☐ Memory ☐ Homonymous Hemianopsia
☐ Low Vision R/L Eye ☐ Other: _____

☐ **Physical Therapy**
- ☐ Evaluation
- ☐ Therapeutic Exercise
- ☐ Electrical Stimulation
- ☐ Ultrasound
- ☐ Gait Training
- ☐ Manual Therapy
- ☐ Functional Training
- ☐ E-Stim
- ☐ Wheelchair Evaluation
  - ☐ Power
  - ☐ Manual
  - ☐ Seating Assessment
- ☐ Other: _____

☐ **Occupational Therapy**
- ☐ Evaluation
- ☐ Therapeutic Exercise
- ☐ Splinting
- ☐ Functional Training
- ☐ Self Care
- ☐ Manual Therapy
- ☐ Cognitive Treatment
- ☐ Functional Visual Task
- ☐ Other: _____

☐ **Speech Therapy**
- ☐ Evaluation
- ☐ Cognitive Eval / Treatment
- ☐ Dysphagia Treatment
- ☐ Other: _____

☐ **Precautions**
- ☐ None
- ☐ Safety
- ☐ Seizure
- ☐ Cardiac
- ☐ Weight Bearing _____
- ☐ Range of Motion _____
- ☐ Other: _____

Goal(s): ☐Maximize Home Function ☐Maximize Community Function ☐Other: _____
Frequency: _____ Times per week **Duration:** _____ Weeks
Precautions: _____ ☐None

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. The plan of care as outlined above and/or the initial evaluation report was established by the Physician, therapist or speech pathologist. The physician will periodically approve this plan and recertification will occur at least once every 10 visits or every 60 days (whichever comes first). The services provided to the patient are required.

Physician's Name: _____
M.D. or D.O's Signature ONLY* _____ Date: _____
NPI# _____

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