ABILITY KC®

THERAPEUTIC PRESCHOOL OUTPATIENT THERAPY CLINIC PRESCRIPTION

3101 Main Street | Kansas City, MO 64111 | T: 816.751.7783 | F: 816.751.7984

Name: _____ Date of Birth: _____

Diagnosis / Symptoms: _____

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

THERAPY NEEDS:

- ☐ Gross Motor
- ☐ Speech/Articulation
- ☐ Ataxia
- ☐ Aggression
- ☐ Emotional Concerns
- ☐ Fine Motor
- ☐ Expressive/Receptive Language
- ☐ Balance
- ☐ Behavior Concerns
- ☐ Other: _____
- ☐ Sensory Integration
- ☐ Oral Motor
- ☐ Gait Disturbance
- ☐ Social Concerns

☐ **Physical Therapy**
- ☐ Assess & Treat
- ☐ Therapeutic Exercise
- ☐ Gait Training
- ☐ Functional Training
- ☐ Gross Motor Skills
- ☐ Aquatic Therapy
- ☐ Other: _____

☐ **Speech Therapy**
- ☐ Assess & Treat
- ☐ Dysphagia Treatment
- ☐ Speech Language Tx
- ☐ Cognitive Eval/Treatment
- ☐ Other: _____

☐ **Occupational Therapy**
- ☐ Assess & Treat
- ☐ Therapeutic Exercise
- ☐ Functional Training
- ☐ ADL/Self Care
- ☐ Fine Motor Skills
- ☐ Sensory Integration
- ☐ Aquatic Therapy
- ☐ Other: _____

☐ **Applied Behavior Analysis**
- ☐ Assess & Treat
- ☐ Other: _____

☐ **Precautions**
- ☐ Universal
- ☐ Safety
- ☐ Cardiac
- ☐ Swallow
- ☐ Seizure
- ☐ Orthostasis
- ☐ Diabetic
- ☐ Avoid Over-Fatigue
- ☐ Anticoagulation
- ☐ Weight Bearing _____
- ☐ Range of Motion _____
- ☐ Other: _____

Certification: Signature below certifies that during the course of treatment as outlined above in physical therapy, occupational therapy, speech pathology and/or ABA that the patient will be under the care of the ordering physician. A licensed therapist will revise the program in keeping with the child's progress.

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.*