ABILITY KC®

ADAPTIVE COMMUNICATION, ASSISTIVE TECHNOLOGY SERVICES & 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:

☐ L. Hemi ☐ R. Hemi ☐ Aphasia ☐ Dysarthria ☐ Non-Verbal ☐ Coordination
☐ Spasticity ☐ Neglect ☐ Weakness ☐ Low Vision ☐ Expressive/Receptive Language
☐ Other: _____

Occupational Therapy

- ☐ Evaluation
- ☐ Functional Training
- ☐ Self Care/Environmental Controls
- ☐ Adapted Computer/Digital Access
- ☐ Adapted Access to Print

Speech Pathology

- ☐ AAC Speech and OT Evaluation and TX
- ☐ AAC Speech Only Evaluation and TX
- ☐ Speech Therapy

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 & NPI: _____

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. 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.

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

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