3011 Baltimore Ave.
Kansas City, MO 64108
816-751-7783 (office)
816-751-7984 (Fax)

ADULT DAY PROGRAM PRESCRIPTION

PLEASE ATTACH PATIENT DEMOGRAPHICS AND INSURANCE SHEET TO THIS FORM!

Name: _____ Date of Birth: _____

Primary Diagnosis: _____

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

THERAPY NEEDS:

☐ L. Hemi ☐ R. Hemi ☐ Gait ☐ Balance ☐ Coordination ☐ Cognition
☐ Memory ☐ Aphasia ☐ Dysarthria ☐ Vision ☐ Ataxia ☐ Neglect
☐ Functional Mobility ☐ Other: _____

☐ **Physical Therapy**
- ☐ Evaluation
- ☐ Transfers
- ☐ Ambulation
- ☐ Balance
- ☐ Strengthening/Endurance
- ☐ Coordination
- ☐ Orthotics
- ☐ Prosthetics
- ☐ Biofeedback
- ☐ Soft Tissue Massage
- ☐ E-Stim
- ☐ FES
- ☐ Desensitization
- ☐ ROM
- ☐ Wheelchair Evaluation
  - ☐ Power
  - ☐ Manual
  - ☐ Seating Assessment
- ☐ Other: _____

☐ **Occupational Therapy**
- ☐ Evaluation
- ☐ ADL/IADL
- ☐ Orthotics
- ☐ Prosthetics
- ☐ Vision
- ☐ Home Management/Child Care
- ☐ Soft Tissue Massage
- ☐ E-Stim
- ☐ Desensitization
- ☐ ROM
- ☐ Strengthening
- ☐ Casting/Serial
- ☐ Driving Evaluation
- ☐ Adapted Computer/Digital Access
- ☐ Adapted Access to Print
- ☐ Other: _____

☐ **Speech Therapy**
- ☐ Evaluation
- ☐ Cognition
- ☐ Communication
- ☐ Oral Motor Function
- ☐ Swallowing
- ☐ Augmentative Communication
- ☐ Other: _____

☐ **Precautions**
- ☐ None
- ☐ Anticoagulation
- ☐ Safety
- ☐ Swallow
- ☐ Seizure
- ☐ Orthostasis
- ☐ Diabetic _____
- ☐ Cardiac _____
- ☐ Sensory Deficit _____
- ☐ Weight Bearing _____
- ☐ Range of Motion _____
- ☐ Other: _____

☐ **Psychology/Social Work**
- ☐ Screen
- ☐ Competency Evaluation
- ☐ Neuropsych. Evaluation
- ☐ Adjustment Counseling
- ☐ Group Counseling
- ☐ Family Counseling
- ☐ Behavior Management
- ☐ Relaxation/Pain Management
- ☐ Social Skills
- ☐ Other: _____

■ **Nursing**
- ■ Assessment and treatment
- ☐ Other: _____

Goal(s): ■ Maximize Home Function ■ Maximize Community Function ☐ Other: _____

Frequency: 3-5 Times per week **Duration:** 4-6 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.*