



3011 Baltimore Ave.
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PEDIATRIC / ADOLESCENT 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 Ataxia Weakness Vision Express/Recep Language
- Neglect Functional Mobility Other: _____

Physical Therapy

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

Occupational Therapy

- Evaluation/Treatment
- ADL/IADL
- Orthotics
- Prosthetics
- Functional Visual Task
- Home Management/Child Care
- Soft Tissue Massage
- FES
- E-Stim
- Desensitization
- ROM
- Strengthening
- Casting/Serial
- Driving Evaluation
- Adapted Computer/Digital Access
- Adapted Access to Print
- 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: _____

Speech Therapy

- Evaluation/Treatment
- Cognition
- Communication
- Oral Motor Function
- Swallowing
- Augmentative Communication
- Other: _____

Nursing

- Assess & Treat
- Other: _____

Community/School Re-entry

Frequency/Duration of Services:

_____ times per week for _____ weeks.

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.