

## 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):	
☐ Dysphagia ☐ Aphasia ☐ M	Gait 🔲 Balance 🔲 D Memory 🗀 Homonymous Hen Other:	mianopsia
□ Evaluation □ Therapeutic Exercise □ Electrical Stimulation □ Ultrasound □ Gait Training □ Manual Therapy □ Functional Training □ E-Stim □ Wheelchair Evaluation □ Power	□ 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: □ Other
Goal(s): Maximize Home Functions: Times per well Precautions:	eek <b>Duration:</b> Weel	unction □Other:ks
<b>Certification:</b> Signature below certifications speech therapy that the patient will be a and/or the initial evaluation report was experiodically approve this plan and recent comes first). The services provided to the	under the care of the ordering physicial established by the Physician, therapist of tification will occur at least once every	n. The plan of care as outlined above or speech pathologist. The physician will
Physician's Name: M.D. or D.O's Signature ONLY* NPI#		Date:

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