ABILITY KC®

PEDIATRIC / ADOLESCENT 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): _____

THERAPY NEEDS:

☐ L. Hemi ☐ R. Hemi ☐ Gait ☐ Balance ☐ Fine Motor ☐ Cognition
☐ Memory ☐ Swallow ☐ Spasticity ☐ Dysarthria ☐ Coordination ☐ Ataxia
☐ Apraxia ☐ Functional Mobility ☐ Expressive/Receptive Language
☐ Other: _____

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

☐ **Speech Therapy**
- ☐ Assess & Treat
- ☐ Cognition Eval/Treatment
- ☐ Dysphagia Treatment
- ☐ Other: _____

☐ **Occupational Therapy**
- ☐ Assess & Treat
- ☐ Therapeutic Exercise
- ☐ Functional Training
- ☐ ADL/Self Care
- ☐ Fine Motor Skills
- ☐ Sensory Integration
- ☐ Aquatic Therapy
- ☐ 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 outllined above in physical therapy, occupational therapy and speech therapy 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.*