WHEELCHAIR CLINIC OUTPATIENT PRESCRIPTION

PLEASE ATTACH PATIENT DEMOGRAPHIC SHEET TO THIS FORM!

Name: ______________________ Date of Birth: ______________

Primary Diagnosis: ______________________

ICD-10 Code(s): ______________________ SS#: ______________

Phone: ______________________ Phone (other): ______________

REHAB DIAGNOSIS:

☐ L. Hemi ☐ R. Hemi ☐ Paraplegia ☐ Quadriplegia ☐ Paraparesis ☐ Quadriparesis

☐ Spasticity ☐ Neglect ☐ Non-Verbal ☐ Low Vision ☐ Coordination

☐ Other: ______________________

☐ **Wheelchair & Seating Evaluation**

☐ Details: ______________________

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Precautions

☐ None

☐ Seizure

☐ Weight Bearing: ______________

☐ Range of Motion: ______________

☐ Other: ______________

Goal(s): ☐ Maximize Home Function ☐ Maximize Community Function ☐ Other: ______________

Frequency: _______ Times per week **Duration:** _______ Weeks

REQUIRED INFORMATION:

Physician Name ______________________ **NPI#:** ______________

Address: ______________________

Office Phone: ______________________ **Office Fax**: ______________

Physician 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.*