ABILITY KC

Peds Fax: 816-751-7984
ACCT Fax: 816-751-7984

PEDIATRIC THERAPY PRESCRIPTION

PLEASE ATTACH PATIENT DEMOGRAPHICS AND INSURANCE SHEET TO THIS FORM

Patient Name: _____ Date of Birth: _____

Primary Diagnosis: _____ Phone: _____

Check the program are you referring to (REQUIRED):

☐ Pediatric/Adolescent Day Program ☐ Pediatric/Adolescent Outpatient Program

☐ ACCT Program - Adaptive Communication, Assistive Tech & Computer Technology Program

ORDERS AND THERAPY NEEDS (REQUIRED):

☐ L Hemi ☐ R Hemi ☐ Gait ☐ Balance ☐ Coordination ☐ Cognition
☐ Memory ☐ Ataxia ☐ Weakness ☐ Low Vision ☐ Expressive/Receptive Language
☐ Non-verbal ☐ Neglect ☐ Spasticity ☐ Functional Mobility ☐ Other_____

☐ **Physical Therapy**

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

☐ **Community / School Re-entry**

☐ **Occupational Therapy**

- ☐ Evaluation & Treat
- ☐ ADL / IADL
- ☐ Orthotics
- ☐ Prosthetics
- ☐ Functional Visual Task
- ☐ Soft Tissue Massage
- ☐ FES
- ☐ E-Stim
- ☐ Desensitization
- ☐ ROM
- ☐ Strengthening
- ☐ Casting / Serial
- ☐ Aquatics
- ☐ Other: _____

☐ **Nursing (**required for Day Program)**

- ☐ Assess & Treat

☐ **Speech Therapy**

- ☐ Evaluation & Treatment
- ☐ Cognition
- ☐ Communication
- ☐ Oral Motor Function
- ☐ Swallowing

☐ **Psychology / Social Work**

- ☐ Screen
- ☐ Adjustment Counseling
- ☐ Behavior Management
- ☐ Other: _____

☐ **Adaptive Communication/Assistive Technology (ACCT Program)**

Occupational Therapy

- ☐ Assistive Tech Eval and Treat
- ☐ Adapted Computer/Digital Access
- ☐ Adapted Access to Print
- ☐ Assistive Technology for Leisure

Speech AAC

- ☐ AAC Speech and OT Eval & Treat
- ☐ AAC Speech only Eval & Treat
- ☐ Speech Therapy for AAC Training

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

Frequency: _____ times per week **Duration:** _____ Weeks

Precautions: _____ ☐ None

Certification: Signature below certifies that during the course of treatment as outlined above 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 Printed Name: _____ NPI# _____

MD or DO Signature: _____ Date: _____

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

Revised Jan 2026