

## ASSISTIVE TECHNOLOGY OUTPATIENT PRESCRIPTION & PLAN OF CARE

**ATTENTION:** CORF Medicare Regulations require that ALL sections of this form be completed.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Primary Diagnosis: \_\_\_\_\_ ICD-10 code(s): \_\_\_\_\_

Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

### Therapy Needs:

- L. Hemi     R. Hemi     Non-Verbal     Dysarthria     Aphasia     Quadriplegia  
 Apraxia     Spasticity     Weakness     Low Vision     Expressive/Receptive Language  
 Ataxia     Other: \_\_\_\_\_

### Occupational Therapy

- OT Evaluation for Assistive Tech

#### OT Goals: (Must check at least one)

- Improve technology access & skills  
 Improve access to print  
 Improve access to digital technology  
 Improve IADL skills through assistive tech  
 Other OT goals: \_\_\_\_\_

### Speech Therapy

- Speech Evaluation for AAC  
 OT & Speech Evaluation for AAC

#### Speech Goals: (Must check at least one)

- Obtain appropriate AAC device  
 Improve skills for use of AAC  
 Other SP goals: \_\_\_\_\_

### Precautions/Contraindications:

- None     Swallow     Fall Risk     Elopement     Seizure     Self-injurious  
 Other: \_\_\_\_\_

**Frequency:** \_\_\_\_\_ times per week for **Duration:** \_\_\_\_\_ weeks

**Certification:** I certify that this patient is under my care and requires skilled rehabilitation services. The CORF service(s) ordered in this prescription and plan of care are medically necessary and the plan of care is established by me, as the referring physician. The plan is to be reviewed in collaboration with the facility therapists and recertified as required by Medicare regulations.

Physician's Name (printed): \_\_\_\_\_ NPI# \_\_\_\_\_

Physician Signature (MD or DO ONLY\*) \_\_\_\_\_ Date: \_\_\_\_\_

*\*Only MD's or DO's can sign therapy orders per Medicare CORF regulations. NPs and PA's cannot sign CORF orders.*