ABILITY KC

Admissions Office
816-751-7783 (Ph)
816-751-7984 (Fax)

DAY PROGRAM PRESCRIPTION AND PLAN OF CARE

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

Patient Name: _____ DOB: _____

Phone: _____ Age: _____

Primary Diagnosis: ☐ Stroke ☐ Brain Injury ☐ Spinal Cord Injury ☐ Amputation ☐ Other (Specify)

☐ Specific Primary Diagnosis: _____

Therapy Needs/Rehab Diagnoses:

☐ L Hemi ☐ R Hemi ☐ Gait ☐ Balance ☐ Coordination ☐ Weakness
☐ Neglect ☐ Functional Mobility ☐ Cognition ☐ Expressive/Receptive Language ☐ Nonverbal
☐ Ataxia ☐ Vision ☐ Aquatics ☐ Exoskeleton ☐ Other: _____

Physical Therapy

☐ PT Evaluation

PT Goals: (Must check at least one)

☐ Improve Ambulation
☐ Improve Balance/Coord
☐ Improve LE Strength/ROM
☐ Orthotics/Prosthetics
☐ Serial Casting
☐ Wheelchair / Seating
☐ Improve W/C skills
☐ Other PT goal(s):

_____

Occupational Therapy

☐ OT Evaluation

OT Goals: (Must check at least one)

☐ Improve ADL/IADL
☐ Improve UE Coordination
☐ Improve UE ROM/Strength
☐ Improve Visual skills
☐ Orthotics/Prosthetics
☐ Serial Casting
☐ Other OT goal(s):

_____

Speech Therapy

☐ Speech Evaluation

SLP Goals: (Must check at least one)

☐ Improve Swallowing
☐ Improve Speech Sound Production
☐ Improve Communication
☐ Improve Memory
☐ Improve Cognition
☐ Improve Augmentative Communication
☐ Other SLP goal(s):

_____

☒ Nursing

☒ Assess and Treat

☒ Social Work

☒ As appropriate

☐ Psychology

☐ As appropriate

Precautions/Contraindications:

☐ None ☐ Swallow ☐ Fall Risk ☐ Safety ☐ Seizure ☐ Anticoagulation ☐ Diabetic
☐ Other: _____

Frequency: _____ times per week for **Duration:** _____ weeks

Certification: I certify that this patient 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 or as the CORF physician. After the initial evaluations, the CORF physician will review the plan of care in collaboration with the therapists and recertify the plan of care as required by Medicare regulations.

Physician's Name: _____ 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.*

Updated April 2026