

Outpatient Therapy Prescription Form

Name: _____ DOB: _____ Date: _____

Diagnosis : _____ Dx Code : _____

Surgical Procedure: _____ Onset Date: _____ Precautions: _____

PHYSICAL THERAPY

- | | | |
|---|--|--|
| <input type="checkbox"/> Evaluate and Treat | <input type="checkbox"/> Home Exercise Program | <input type="checkbox"/> Lymphedema (<i>Main campus</i>) |
| <input type="checkbox"/> Aquatic Therapy (<i>Main campus</i>) | <input type="checkbox"/> FCE (<i>Main campus</i>) | <input type="checkbox"/> Foot Orthotics |
| <input type="checkbox"/> Gait Training | <input type="checkbox"/> ROM active passive | <input type="checkbox"/> Strengthening/PRE's |
| <input type="checkbox"/> Spine Rehab | <input type="checkbox"/> Posture/Body Mechanics | <input type="checkbox"/> Total Joint Rehab |
| <input type="checkbox"/> Vestibular/Balance Program | <input type="checkbox"/> Pilates | <input type="checkbox"/> Wheelchair Eval (<i>Main campus</i>) |
| <input type="checkbox"/> Protocol _____ | <input type="checkbox"/> Wound Care (<i>Main campus</i>) | <input type="checkbox"/> Pressure Mapping (<i>Main campus</i>) |
| <input type="checkbox"/> Modality of Choice _____ | | |
| <input type="checkbox"/> Other _____ | | |

OCCUPATIONAL THERAPY

- | | | |
|--|---|---|
| <input type="checkbox"/> Evaluate and Treat | <input type="checkbox"/> Home Exercise Program | <input type="checkbox"/> Sensory Retraining |
| <input type="checkbox"/> ADLs | <input type="checkbox"/> Adaptive Equipment Training | <input type="checkbox"/> ROM active passive |
| <input type="checkbox"/> Driver's Screen/Training | <input type="checkbox"/> Hand Therapy: elbow/wrist/hand | <input type="checkbox"/> Visual Perception |
| <input type="checkbox"/> Splints static dynamic | <input type="checkbox"/> Cognitive Retraining | |
| <input type="checkbox"/> Modality of Choice _____ | | |
| <input type="checkbox"/> Other _____ | | |

SPEECH THERAPY

- | | | |
|--|--|--|
| <input type="checkbox"/> Evaluate and Treat | <input type="checkbox"/> Home Exercise Program | <input type="checkbox"/> Dysphagia Therapy |
| <input type="checkbox"/> Speech/Language Therapy | <input type="checkbox"/> Cognitive Therapy | |
| <input type="checkbox"/> Modified Barium Swallow | <input type="checkbox"/> FEES (<i>Main campus</i>) | |
| <input type="checkbox"/> Augmentative Alternative Communication Evaluation/Treatment | | |
| <input type="checkbox"/> Other _____ | | |

FREQUENCY AND DURATION

1 2 3 4 5 Times/Week for _____ Weeks

Referring Physician Signature _____ Phone # _____

Print Name _____ Fax # _____

Prescription expires in 90 days

To schedule an evaluation: phone: 513-585-7171, fax: 513-585-5225
Daniel Drake Center Main Campus: 151 W. Galbraith Rd., Cincinnati, OH 45216
Daniel Drake Rehab in West Chester: 7675 Wellness Way #101, West Chester, OH 45069
Daniel Drake Rehab in Clifton: 3130 Highland Ave., 3rd floor, Cincinnati, Ohio 45219