2530 Professional Parkway
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Occupational Therapy Prescription

PATIENT'S NAME: ______________________________

DIAGNOSIS: ______________________________ ONSET: ____________

FREQUENCY: ______________ DURATION: (not to exceed 30 days) ____________

PRECAUTIONS / SPECIAL INSTRUCTIONS: ______________________________

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- ❑ **EVALUATION**
- ❑ Hot / Cold Modalities
- ❑ Ultrasound
- ❑ Electrical Modalities
- ❑ Splinting (please specify)
  - Static: ______________________________
  - Dynamic: ______________________________
- ❑ Joint Mobilization
- ❑ Iontophoresis
- ❑ Phonophoresis
- ❑ Edema Reduction
- ❑ Other: ______________________________
- ❑ Range of Motion:
  - ❑ Passive ❑ Act Asst ❑ Act
- ❑ Therapeutic Exercise:
  - ❑ Active ❑ Resistive ❑ Fine Motor / Dexterity
- ❑ Sensory re-education / desensitization
- ❑ Soft Tissue Mobilization / Myofascial Release / Scar Tissue
- ❑ Wound Care / Whirlpool — Dressing(s): ______________________________

Medicare Certification: I certify_____ recertify _____ that I have examined the patient and Occupational Therapy is necessary and that service will be furnished on an outpatient basis while the patient is under my care, and that the plan established will be reviewed every 30 days or more if the patient's conditions require. I estimate that these services will be needed for about ________________ (specify number of days/weeks/months).

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DATE *PHYSICIAN'S SIGNATURE*