ABILITY KC™

Medical Rehabilitation • Therapeutic Preschool • Employment Services

(Formerly RIKC)

Outpatient Prescription

3011 Baltimore Ave. | Kansas City, MO 64108 **Phone: 816-751-7783** **Fax: 816-751-7984**

Name: _____ **Age**: ____ **Date of birth**: _____

Primary Diagnosis: _____ **Phone (H):**_____ **Phone (W)** _____

Rehab Diagnoses: ☐**L hemi** ☐**R hemi** ☐**gait** ☐**balance** ☐**dysarthria** ☐**cognition** ☐**dysphagia** ☐**gait** ☐**aphasia** ☐**memory** ☐**homonymous hemianopsia** ☐ **low vision R/L eye** ☐ **other**_____

Physical Therapy
- ☐ **Evaluation**
- ☐ **Wheelchair Evaluation**
- ☐ **Therapeutic Exercise**
- ☐ **Electrical Stimulation**
- ☐ **Ultrasound**
- ☐ **Gait Training**
- ☐ **Manual Therapy**
- ☐ **Functional Training**
- ☐ **other**_____

Occupational Therapy
- ☐ **Evaluation**
- ☐ **Therapeutic Exercise**
- ☐ **Splinting**
- ☐ **Functional training**
- ☐ **Self Care**
- ☐ **Manual Therapy**
- ☐ **Cognitive Treatment**
- ☐ **Functional Visual Task**
- ☐ **other** _____

Speech Pathology
- ☐ **Evaluation**
- ☐ **Dysphagia Tratment**
- ☐ **Speech Language Tx**
- ☐ **Cognitive Eval/Treatment**
- ☐ **other**_____

Precautions:
- ☐**None**
- ☐**Safety**
- ☐**Cardiac**
- ☐**Seizure**
- ☐**Weight Bearing** _____
- ☐**Range of motion**_____
- ☐**other** _____

Frequency: _____ **Times Per Week** **Duration:** _____ **Weeks**

Goals:
- ☐ **Maximize Home Function**
- ☐ **Maximize Community Function**
- ☐ **Other**:_____

Certification:

Signature below certifies that during the course of treatment as outlined above in physical therapy, occupational therapy and/or speech pathology that the patient will be under the care of the ordering physician. The plan of care as outlined above and/or in the initial evaluation report was established by the physician, physical therapist, occupational 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 Name: _____ **Physician Signature (No Nurse Practitioner)** _____

Date_____ **Physician NPI#**_____ **Revised Jan 2017**