

ROCHESTER REHABILITATION CENTER
MEDICAL OUTPATIENT SERVICES ~ PRESCRIPTION

Name: _____
 DOB: _____ Telephone: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Insurance(s): _____

 Referral # (if applicable): _____

Date: _____

Diagnosis: _____

PRECAUTIONS: _____

<p><input type="checkbox"/> Physical Therapy - Evaluation & Treatment <input type="checkbox"/> 3x wk <input type="checkbox"/> 2x wk <input type="checkbox"/> 1x wk</p> <p><input type="checkbox"/> Therapeutic Exercise <input type="checkbox"/> Home Exercise Program Instruction <input type="checkbox"/> Aquatic Therapy <input type="checkbox"/> Spinal Rehab • <input type="checkbox"/> McKenzie <input type="checkbox"/> Spinal Stabilization • <input type="checkbox"/> Flexion Based <input type="checkbox"/> Gait Training • <input type="checkbox"/> WBAT <input type="checkbox"/> NWB <input type="checkbox"/> Partial WB <input type="checkbox"/> Balance Training <input type="checkbox"/> Posture/Body Mechanic Training <input type="checkbox"/> Manual Therapy <input type="checkbox"/> Vestibular Rehab <input type="checkbox"/> Transfer/Mobility Training <input type="checkbox"/> Home TENS Unit <input type="checkbox"/> Modalities: _____ <input type="checkbox"/> Other: _____ _____</p>	<p><input type="checkbox"/> Occupational Therapy - Evaluation & Treatment <input type="checkbox"/> 3x wk <input type="checkbox"/> 2x wk <input type="checkbox"/> 1x wk</p> <p><input type="checkbox"/> Therapeutic Exercise • <input type="checkbox"/> AAROM <input type="checkbox"/> AROM • <input type="checkbox"/> PROM <input type="checkbox"/> Resisted <input type="checkbox"/> ADL/IADL Training – Clinical <input type="checkbox"/> Visual-Perceptual Skills Training <input type="checkbox"/> Energy Conservation/Work Simplification <input type="checkbox"/> Home Independent Living Eval <input type="checkbox"/> Splinting <input type="checkbox"/> Home Exercise Instruction <input type="checkbox"/> Ergonomic Evaluation <input type="checkbox"/> Modalities: _____ <input type="checkbox"/> Other: _____</p>	<p><input type="checkbox"/> Speech Therapy - Evaluation & Treatment <input type="checkbox"/> 3x wk <input type="checkbox"/> 2x wk <input type="checkbox"/> 1x wk</p> <p><input type="checkbox"/> Speech & Language <input type="checkbox"/> Augmentative/Alternative Communication <input type="checkbox"/> Voice <input type="checkbox"/> Dysphagia <input type="checkbox"/> Deep Pharyngeal Neuromusculatory Stimulation (DPNS) <input type="checkbox"/> Other: _____</p>
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Return completed prescription to:
Rochester Rehabilitation – Medical Outpatient Services
 1000 Elmwood Avenue, Ste. 600, Rochester, NY 14620-3097
Telephone: 585-271-1894 FAX: 585-442-6883

Referred by (please print name): _____ Phone: _____

Physician Specialty: __ GP __ Ortho __ Neuro __ Gerontology __ Psych __ Internal med __ Cardio __ Other: _____

Agency/Program: _____

Address: _____ State: _____ Zip Code: _____

Physician's Signature

Date

NPI #

10/23/09