

Therapy Station

Progressing towards Independence

Patient Name: _____

OCCUPATIONAL THERAPY EVALUATION

AUTHORIZATION PERIOD: _____ **TO** _____

Patient:	Examiner:
DOB:	DOE:
CA:	Diagnosis:
Parents:	Physician:

Medical/Background History: _____

Neuromuscular control: (ROM, Tone, Strength, Reflex, Coordination, and Balance)

Fine Motor/Manipulatory skills: (Grasping, Visual-Motor integration, Object Manipulation, Hand Writing)

Activities of Daily Living: (Feeding, Drinking, Grooming, Dressing, Bathing, Toileting, Coloring, and Cutting)

Splint/Wheel chair: _____

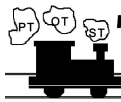
Functional Mobility: (Toilet Transfer, Bed Mobility, and Wheel Chair Mobility) _____

12760 Westwood Lakes Blvd. Tampa. FL 33626. PH: (813) 855-9791 Fax: (813) 814-4520

⊗ Physical Therapy

⊗ Occupational Therapy

⊗ Speech Therapy



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Patient Name: _____

Assessment: _____

PATIENT PLAN OF CARE

Recommended Modalities:

A/AA/PROM Sensory Integration Adaptive equipment ADL
 Endurance Perceptual Skills Therapeutic Exercise NDT
 Home Program Transfer Training Care giver training Splint

Recommended Treatment sessions:

It is recommended that the above-mentioned patient receive _____ occupational therapy treatment sessions, up to _____ minutes with in _____ months to maximize functional abilities.

Justification for longer or no treatment session recommended: *(please write reason if patient require more than 30 minutes per treatment session)*

Goals: The patient will be able to:

1. _____

2. _____

3. _____

4. _____

Occupational Therapist

Date

Dear Physician:

Thank you for the referral. Please sign and return the treatment plan to Therapy Station. Your signature will convert this report into a prescription.

I certify that the above treatment plan is medically necessary and valid.

Physician's Signature

Date

Medipass Auth. Number (if applicable)

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