A&M Therapy , Inc.

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☐ Evaluate/Treat Occupational Therapy

Date:_______________________________

Patient Name: ______________________

Phone: ______________________

Diagnosis: ______________________

Precautions: ______________________

Type of Surgery : ______________________

Frequency & Duration of Treatment: ______________________

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Modalities and Procedures

- ☐ Hot/Cold Packs
- ☐ Ultrasound
- ☐ Electrical Stimulation for Pain Control
- ☐ Electrical Stimulation for Muscle Strength
- ☐ T.E.N.S. (set up)

Manual Techniques

- ☐ Massage/Soft Tissue Mobilization
- ☐ Joint Mobilization
- ☐ Manual Stretching
- ☐ Myofascial Release
- ☐ Muscle Energy-Strain Counter Strain

Neuromuscular Re-education

- ☐ Balance Training
- ☐ PNF Exercises

Joint Rehabilitation

- ☐ Shoulder
- ☐ Elbow
- ☐ Wrist
- ☐ Hand Therapeutic Exercise
- ☐ Home Program
- ☐ Directed Gym Program

Therapeutic Exercise

- ☐ Home Program
- ☐ Directed Gym
- ☐ ROM Exercises

Therapeutic Activities

- ☐ Self Care/ADL training
- ☐ Functional Mobility/Transfer Training
- ☐ Ergonomics/Body Mechanics Training
- ☐ Fine Motor coordination/

Special Programs

- ☐ Hand Splint
- ☐ Handwriting
- ☐ Joint Protection
- ☐ Energy Conservation
- ☐ Aging in Place
- ☐ Home Safety Assessment
- ☐ Environmental Modification
- ☐ Adaptive Equipment
- ☐ Client/Caregiver Education
- ☐ Chronic Disease Management

Additional Comments: ______________________

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This prescription is an order to evaluate and treat unless specified otherwise above.

I CERTIFY THAT THE ABOVE TREATMENT PLAN IS MEDICALLY NECESSARY AND IS APPROVED.

Physician Signature ______________________ Date ______________

Print Physician Name ______________________NPI Number______________

This must be signed by Doctor in order for you to receive treatment