easterseals
Capital Region & Eastern Connecticut

Outpatient Rehabilitation Services Prescription Form

Patient Name: _____ DOB: _____ Preferred Language: _____

Address: _____ City: _____ State: _____

Email Address: _____ Home Ph #: _____ Cell Ph #: _____

Insurance: _____ Policy ID: _____ Subscriber: _____

Does the patient have a conservator/guardian (*for patients ≥ 18 years old*)? ☐ No ☐ Yes

If yes, list name & contact information of conservator: _____

Current ICD-10 Diagnoses: _____ Rehab Concerns & Goals: _____

Precautions/Contraindications (*check all that apply*):

☐ Cognition/Behaviors ☐ Orthopedic ☐ Safety Awareness ☐ Language ☐ GI/GU

☐ Cardiopulmonary ☐ Weight Bearing ☐ Hearing/Vision ☐ Skin ☐ Check here if none

Explanation for those that apply: _____

Physical Therapy

☐ Evaluation/Treatment[1]

May Include:

- ☐ ROM/Strengthening
- ☐ Functional Mobility
- ☐ Gait Training
- ☐ Fall Risk Assessment
- ☐ Home Exercise Program
- ☐ E-Stim / Ultrasound
- ☐ Moist Heat/Cold
- ☐ Orthotic/Prosthetic Mgt
- ☐ Wheelchair Assessment
- ☐ Other _____

Occupational Therapy

☐ Evaluation/Treatment[1]

May Include:

- ☐ ROM/Strengthening
- ☐ Functional ADLs
- ☐ Sensory Integration
- ☐ Splinting/Contracture Mgt.
- ☐ Visual/Perceptual
- ☐ Functional Cognition
- ☐ Home Exercise Program
- ☐ Oculomotor
- ☐ Wheelchair Assessment
- ☐ Other _____

Speech-Language Pathology

☐ Evaluation/Treatment[1]

May Include:

- ☐ Communication
- ☐ Language
- ☐ Cognitive Therapy
- ☐ Dysphasia Mgt.
- ☐ Home Program
- ☐ Other _____

[1] When only Evaluation/Treatment box is checked, the therapist will determine the appropriate treatment protocols

Social Services

- ☐ Therapy/Counseling
- ☐ Case Management

Please include the following information to avoid a delay in processing and scheduling:

- ☐ Copy of patient's insurance information, including policy ID and insurance subscriber name
- ☐ Recent medical/clinical notes which support medical necessity of rehabilitation services
- ☐ List of active medications
- ☐ Copy of any diagnostic testing results if applicable (e.g., X-ray, MRI, etc.)

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*I certify that Outpatient Rehabilitation Services are **medically necessary** for my patient.*

MD* Name (please print):		Ph #:		Fax #:	
MD* Signature:		Date:		NPI:	
MD* Physical Address:					
MD* Email Address:					

*In lieu of MD, acceptable referring providers include: DO, PA, APRN, LCSW.

To avoid delay in scheduling, please provide all information above along with relevant medical/clinical records pertinent to services being requested including active medications and diagnostic imaging.

Return via fax to 860-748-4432. Thank you!