



Outpatient Rehabilitation Services & Prescription Form

Patient Name: _____ DOB: _____ Preferred Language: _____
 Address: _____ Home Ph #: _____ Cell Ph #: _____
 Insurance: _____ Policy ID: _____ Insurance Subscriber (if not patient): _____
 Parent/Guardian/Conservator Name: _____

Guardian/Conservator Address and Phone# (if different from above): _____

Current ICD-10 Diagnoses: _____ R/O Diagnoses: _____

Reason for Referral / Rehab Concerns & Goals (incl. onset and progression of concerns & difficulties prompting referral):

Psychosocial Services

- Neuropsychological Testing Psychotherapy/Counseling Social Work/Case Management

Physical Therapy

- Evaluation/Treatment¹

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

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/Treatment¹

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/Treatment¹

May Include:

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

Precautions/Contraindications for PT, OT, SLP (check all that apply) Check here if none

- Skin _____ Orthopedic _____ Cognition/Behaviors _____
 Cardiopulmonary _____ Safety Awareness _____ Language _____
 GI/GU _____ Weight Bearing _____ Hearing/Vision _____

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

MD* Name (please print):	NPI:	
MD* Signature:	Date:	
MD* Phone Number:	Fax:	

*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 and other assessment.
 Return via fax to 860-748-4432. Thank you!**

Medical Services & Administration • 100 Deerfield Road, Windsor, CT 06095 • 860-270-0600
Vocational & Veterans Services • 22 Prestige Park Circle, East Hartford, CT 06108 • 860-728-1061
Veterans & Adult Day Services • 24 Stott Avenue, Norwich, CT 06360 • 860-859-4148