easterseals
Capital Region & Eastern Connecticut

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/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.
- ☐ Audiological Screen
- ☐ Home Program
- ☐ Other _____

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

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!