

PATIENT INFORMATION

Patient Name: _____

Phone Number: _____ Alternate Number: _____

Date of Birth (mm/dd/yyyy): _____ Authorization Number: _____

Diagnosis (ICD-10 with narrative description): _____

Precautions: _____

OCCUPATIONAL THERAPY EVALUATION AND TREATMENT

- | | | |
|-----------------------------------------------|-----------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Visual Motor Skills | <input type="checkbox"/> Activities of Daily Living | <input type="checkbox"/> Aquatic Therapy (Barlite only) |
| <input type="checkbox"/> Grasping Items | <input type="checkbox"/> Attention | <input type="checkbox"/> Decreased Range of Motion |
| <input type="checkbox"/> Age-Appropriate Play | <input type="checkbox"/> Postural Instability | <input type="checkbox"/> As Indicated by OT |
| <input type="checkbox"/> Handwriting | <input type="checkbox"/> Sensory Issues | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Coordination | <input type="checkbox"/> Motor Planning | |

PHYSICAL THERAPY EVALUATION AND TREATMENT

- | | | |
|-----------------------------------------------------|------------------------------------------------|-----------------------------------------------------------------------|
| <input type="checkbox"/> Strengthening | <input type="checkbox"/> Gait/Balance Training | <input type="checkbox"/> Scoliosis-Specific Treatment (Downtown only) |
| <input type="checkbox"/> Developmental Skills | <input type="checkbox"/> PROM/AAROM/AROM | <input type="checkbox"/> Aquatic Therapy (Barlite only) |
| <input type="checkbox"/> Neuromuscular Re-education | <input type="checkbox"/> Manual Therapy | <input type="checkbox"/> Equipment Assessments/Training |
| <input type="checkbox"/> Vestibular Rehab | <input type="checkbox"/> Functional Mobility | <input type="checkbox"/> As indicated by PT |
| <input type="checkbox"/> Endurance Training | <input type="checkbox"/> HEP | <input type="checkbox"/> Other: _____ |

SPEECH THERAPY EVALUATION AND TREATMENT

- | | |
|----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Evaluation and Treatment of Speech Sound Production Only | <input type="checkbox"/> Evaluation and Treatment of Speech Sound production,
Language Comprehension and Expression, and
Oral and Pharyngeal Swallowing Function |
| <input type="checkbox"/> Evaluation and Treatment of Speech Sound Production
with Language Comprehension and Expression | <input type="checkbox"/> Hearing Rehabilitation/Hearing Habilitation |
| <input type="checkbox"/> Evaluation and Treatment of Oral and Pharyngeal
Swallowing Function | <input type="checkbox"/> As Indicated by ST |
| <input type="checkbox"/> Modified Barium Swallow Study Evaluation (Downtown only) | <input type="checkbox"/> Other: _____ |

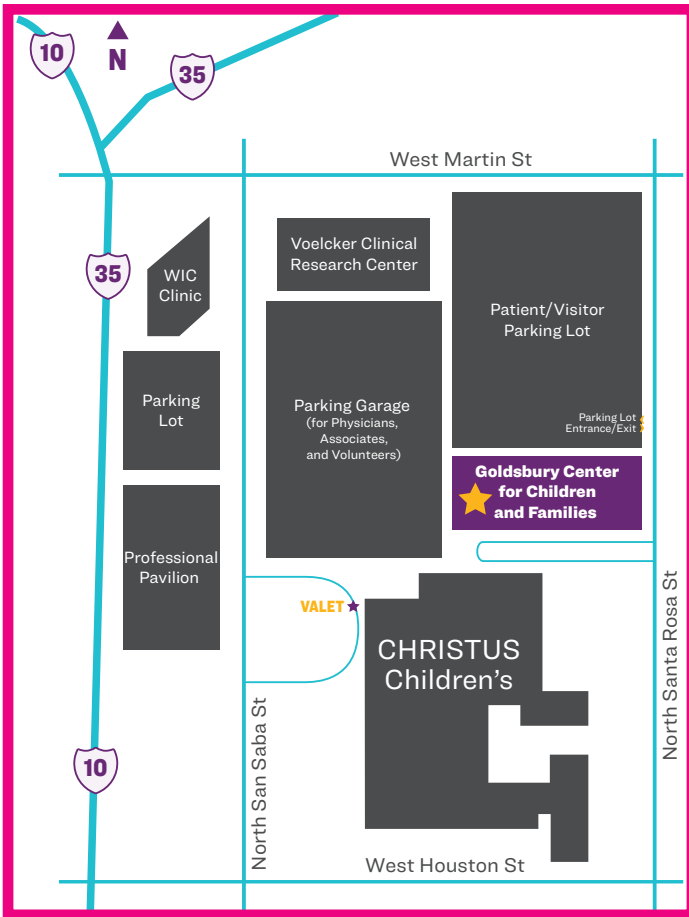
Evaluate and treat as indicated for: _____ visits per week for: _____ weeks/months.

I certify the prescribed treatment is an appropriate course of treatment and the services prescribed are medically necessary.

Physician Signature: _____ Date: _____ Time: _____

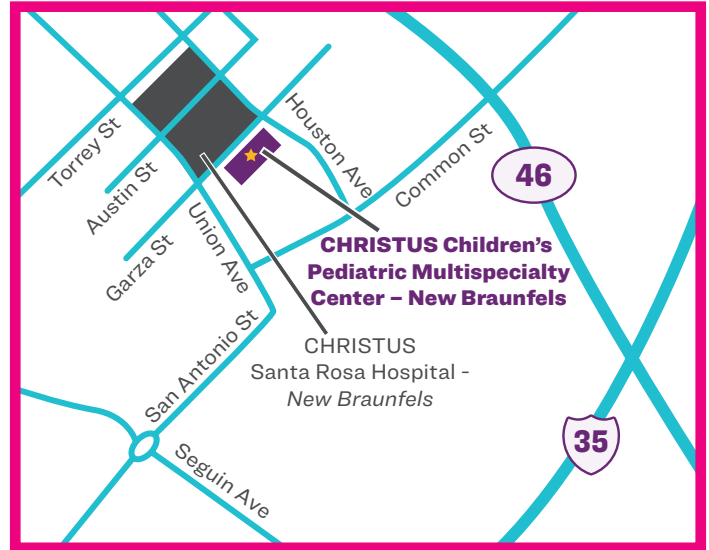
Physician Name (Print): _____ Fax #: _____

LOCATIONS



CHRISTUS Children's Outpatient Rehabilitation Clinic - Downtown

Center for Children and Families, Suite 1615 (First Floor)
 333 North Santa Rosa Street
 San Antonio, Texas 78207
 P: 210.704.3760 F: 210.704.3765



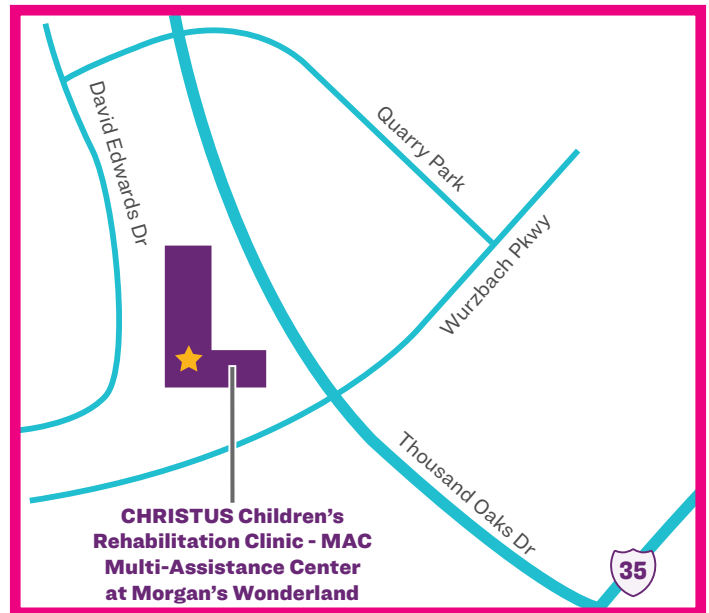
CHRISTUS Children's Outpatient Rehabilitation - New Braunfels

598 North Union Avenue, Suite 230
 New Braunfels, Texas 78130
 P: 830.643.5242 F: 830.643.5254



CHRISTUS Children's Rehabilitation Clinic - Barlite

7390 Barlite Boulevard, Suite 120
 San Antonio, Texas 78224
 P: 210.704.0140 F: 210.704.0138



CHRISTUS Children's Rehabilitation Clinic - MAC Multi-Assistance Center at Morgan's Wonderland

5210 Thousand Oaks Drive, Suite 1351
 San Antonio, Texas 78233
 P: 210.704.3760 F: 210.704.3765