Professional Case Management of SW Florida
PO Box 1151, Venice, FL 34284
Phone: 941-492-2433
Please FAX This Referral to: 941-492-2446

# "FOCUS ON FUNCTION"

An In-Home Occupational Therapy Program
Prescription For Treatment

Patient Name: ______________________ Phone #: ______________________ Date: ____________

Primary Diagnosis: ______________________________________________ Code: ____________

Secondary Diagnosis: ____________________________________________ Code: ____________

Physician Name: ______________________ UPIN#: ____________ NPI#: ________ Phone: ____________

Patient Restrictions/Concerns: ______________________________________________

**Occupational Therapy Treatment**

*(Please check those that apply)*

- ❏ Evaluation
- ❏ Treatment
- ❏ Bathing ❏ Dressing ❏ Self Care
- ❏ ROM-Flexibility Exercise
- ❏ Balanced/Fall Prevention
- ❏ Strengthening Exercise
- ❏ Orthotics/Splinting

**Specific Training Programs**

*(Please check those that apply)*

- ❏ Home Safety Retaining
- ❏ Pulmonary/Energy Conservation
- ❏ Home Management Training
- ❏ Handwriting Retaining
- ❏ Low Vision Management
- ❏ Cognitive Retaining

Special Instructions: ______________________________________________

______________________________________________________________

*I certify that Rehabilitation Services are required by the above patient and that this patient is presently under my care. A Plan of Treatment will be established for continuing care and said Plan will be reviewed at least every thirty (30) days as required.*

______________________________________________ ____________

Physician Signature Date:

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