UC Health
DRAKE CENTER

Outpatient Therapy Prescription Form

Name:_____ DOB:_____ Date:_____

Diagnosis :_____Dx Code :_____

_____

Surgical Procedure:_____Onset Date:_____ Precautions:_____

☐ PHYSICAL THERAPY

☐ **Evaluate and Treat**
☐ Aquatic Therapy (*Main campus*)
☐ Gait Training
☐ Spine Rehab
☐ Vestibular/Balance Program
☐ Protocol_____
☐ Home Exercise Program
☐ FCE (*Main campus*)
☐ ROM active passive
☐ Posture/Body Mechanics
☐ Pilates
☐ Wound Care (*Main campus*)
☐ Lymphedema (*Main campus*)
☐ Foot Orthotics
☐ Strengthening/PRE's
☐ Total Joint Rehab
☐ Wheelchair Eval (*Main campus*)
☐ Pressure Mapping (*Main campus*)
☐ Modality of Choice_____
☐ Other_____
_____

☐ OCCUPATIONAL THERAPY

☐ **Evaluate and Treat**
☐ ADLs
☐ Driver's Screen/Training
☐ Splints static dynamic
☐ Home Exercise Program
☐ Adaptive Equipment Training
☐ Hand Therapy: elbow/wrist/hand
☐ Cognitive Retraining
☐ Sensory Retraining
☐ ROM active passive
☐ Visual Perception
☐ Modality of Choice_____
☐ Other_____
_____

☐ SPEECH THERAPY

☐ **Evaluate and Treat**
☐ Speech/Language Therapy
☐ Modified Barium Swallow
☐ Home Exercise Program
☐ Cognitive Therapy
☐ FEES *(Main campus)*
☐ Dysphagia Therapy
☐ Augmentative Alternative Communication Evaluation/Treatment
☐ Other _____

FREQUENCY AND DURATION

1 2 3 4 5 Times/Week for _____ Weeks

Referring Physician Signature_____ Phone #_____

Print Name_____ Fax #_____

Prescription expires in 90 days

Main Campus: 151 W. Galbraith Rd., Cincinnati, OH 45216, 513-418-2798 option #2, fax 513-418-2550
Drake Rehab at West Chester: 7626 University Court #201, West Chester, OH 45069, 513-475-7454, fax 513-475-7455
Drake Rehab at Stetson Square: 260 Stetson Street #266, Cincinnati, Ohio 45219 513-221-6690, fax 513-221-6693