Positively Playful Occupational Therapy, PLLC

Prescription

Patient Name:___________________________ Date:_____________

Diagnosis (include ICD-9 code):______________________________ DOB:_____________

Precautions:____

Prescription

Occupational therapy evaluation and treatment to be performed by Positively Playful Occupational Therapy, PLLC.
Please note the frequency and duration of the therapy _____________________________per week (ie 1x30 minutes)

__Normalization of muscle tone
__Improvement of coordination
__Improvement of body awareness
__Improvement of motor planning
__Normalization of sensory procession
__Improvement of ADL completion
__Increased trunk stability
__Improvement of head control
__Improvement of balance
__Improvement of postural stability
__Patient/family education
__Other______________________

For a duration of: ______6 months ______12 months _________other

Physician Signature:____ Date:_____________
NPI number:_____________________________
Phone:__________________
Fax:____________________
E-mail:________________________

Please include MD stamp

518.424.2991 ***118 Hurst Road Delmar, NY 12054*** ***positivelyplayfultherapy.com hippoOTR@gmail.com***