# PRESCRIPTION FORM

**Patient Name:** _____

**DOB:** __/__/____ **Diagnoses (ICD10 codes):** _____

**Address:** _____

**Phone:** _____

**Email:** _____

**Primary Insurance:** _____ **ID#** _____

**Secondary Insurance:** _____ **ID#** _____

**Height:** _____ **Weight:** _____

**PLAN: Evaluate and treat by occupational therapy for wheelchair/seating**

*Assessment by a clinical team consisting of a licensed occupational therapist and Assistive Technology Professional (ATP)*

**CONSIDERATIONS:**

- ☐ Power mobility device evaluation (power wheelchair or scooter)
- ☐ Manual wheelchair evaluation
- ☐ Skin management (wheelchair seat cushion or alternative pressure relieving devices)
- ☐ Seating and positioning in a mobility system
- ☑ Other: OT TO EVAL AND TREAT FOR MOBILITY/DME

**ADDITIONAL COMMENTS:**

**Physician Name:** _____

**Physician Signature:** _____

**Date:** __/__/____ **Physician NPI:** _____

**Phone:** _____

**Fax:** _____

**Referral Contact:** _____

***Please send recent patient office visit/chart note with order.***

***LimbTech, LLC 907-351-3261 - LimbTechNC.com (amy@limbtechnc.com)***