

# ADA THERAPY SERVICES, PLLC



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Patient Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Patient Phone: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Medical ICD-10: \_\_\_\_\_

Evaluate and Treat

Treatment Specifics: \_\_\_\_\_

Precautions: \_\_\_\_\_

Services:

Occupational Therapy

Home Safety Evaluation

Job Site Evaluation

Return to Work/Return to School Planning

Community Mobility and Safety Assessment and Training

Frequency & Duration of Treatment: \_\_\_\_\_

Referring Physician (print or stamp): \_\_\_\_\_ Phone: \_\_\_\_\_

Referring Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_