

RUSK INSTITUTE REHABILITATION 240 East 38th Street • New Yorl www.ruskinstitute.org 212-263-6033

Outpatient General Occupational Therapy Referral

FAX to the RUSK BUSINESS OFFICE at (212) 263-0113

Date:	Patient Name:		
Gender: □ Female □ Male	Date of Birth:		
Telephone Number: Home: ()	Cell: (
Patient Address:			
Insured Name:			
	• •• ••	• ••	•• •• •• ••
Medical Diagnosis:		CD 9:	_Onset Date:
OT Prescription for: (please se	elect)		
		Moist Heat/Paraffin/Fluidotherapy	
ADL (Self Care Manage		Contrast bath	
Community ReintegratTherapeutic Exercises			ognitive Skills Development sion-Perceptual Training
UE Training /Neuro Re-Ed/ Manual TherapyAssistive Technology			
Electrical Stimulation Home Modification – Barrier Free Design			
Other		W/C Training	Seating & Mobility
Orthotic Eval /Spint Fal	brication		
Physician Order Frequency an	d Duration:		
• • • • •	•• •• ••	•• ••	
Physician's Name (Please Print):			
License Number:	UPIN:		_NPI#:
Office Telephone: ()		Office Fax: (_)
Physician's Signature:			