NYU Langone MEDICAL CENTER

Ambulatory Care Center
RuskRehabilitation – Occupational Therapy
240 East 38th Street Rm 1718B
New York, NY 10016
www.nyulmc.org/rusk

Outpatient Occupational Therapy
Seating and Mobility Referral

OCCUPATIONAL THERAPY – SEATING AND MOBILITY/ OT-WC

FAX to (212) 263-0113 OR EMAIL to RuskACCIntake@nyumc.org

Date: _____ **Patient Name:** _____

Gender: □ Female □ Male **Date of Birth:**_____

Telephone Number: Home: (_____)_____--_____ Cell: (_____)_____-_____

Patient Address:_____

Primary Insurance: _____Policy Number: _____
Secondary Insurance: _____Policy Number: _____
Insured Name: _____

Medical Diagnosis*:** _____ICD 10*:** _____***Onset Date:*** _____

_____ ALS (amyotrophic lateral sclerosis) [G12.21]
_____ Multiple sclerosis [G35]
_____ Cerebral Palsy [G80.9]
_____ Paraplegia [G82.20]
_____ Tetraplegia [G82.50]
_____Parkinson's disease [G20]

OT Prescription for: **(please select)**

_____OT Power Mobility Evaluation
_____ OT Manual Mobility Evaluation
_____ Wheelchair Delivery and Training
_____ Equipment /Custom Modifications

Physician Order Frequency and Duration: _____

Physician's Name (Please Print): _____
License Number: _____**UPIN:** _____**NPI#:** _____
Office Telephone: (_____)_____-_____**Office Fax:** (___)_____-_____

Physician's Signature:_____