

Patient name: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Frequency: \_\_\_\_\_ days per week for \_\_\_\_\_ weeks

- |   |                                       |
|---|---------------------------------------|
| <input checked="" type="checkbox"/> Occupational Therapy Eval & Treat | <input type="checkbox"/> Job Coach    |
| <input type="checkbox"/> Functional Capacity Evaluation               | <input type="checkbox"/> Job Analysis |
| <input type="checkbox"/> Ergonomic Work Site Assessment               | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Work Tolerance Screening                     | _____                                 |
| <input type="checkbox"/> Work Conditioning Program                    | _____                                 |
| <input type="checkbox"/> Functional Home Living Assessment            | _____                                 |

Physician's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's name (print): \_\_\_\_\_

### PATIENT INSTRUCTIONS

- Please call as soon as possible after receiving this prescription.
- On your first visit, please bring your physician's prescription.
- Dress in comfortable clothing and shoes.
- Please bring photo identification with you.
- Call at least 24 hours in advance if you need to cancel or reschedule.  
Failure to cancel will result in services being billed.

### OUR CLINIC LOCATIONS

#### CLINTON/MACOMB

40450 Hayes Road  
Clinton Township, MI 48038  
P. 586.226.0434  
F. 586.226.2252

#### WESTLAND/WAYNE

32500 W. Warren Road  
Westland, MI 48185  
P. 313.592.0038  
F. 313.592.9055

#### WIXOM/OAKLAND

29650 S. Wixom Road  
Wixom, MI 48393  
P. 248.682.5423  
F. 248.682.0444