HELEN HAYES HOSPITAL

Helen Hayes Hospital, Route 9W, West Haverstraw, NY 10993

Center for Rehabilitation Technology

Assistive Technology Physician Orders

PLEASE PRINT CLEARLY • FAX back to 845-786-4951

Date of referral:

Patient Name: ____________________ DOB: ____________ Phone: ____________

Special Instructions or Precautions: ____________________

REASON FOR REFERRAL

❑ Seating & Mobility Evaluation
❑ Bath & Safety Equipment Evaluation
❑ Assistive Technology Evaluation
❑ Standing Device Evaluation
❑ Augmentative/Alternative Communication Evaluation
❑ Other: ____________

DIAGNOSIS:

❑ ALS ____________
❑ COPD ____________
❑ Multiple Sclerosis ____________
❑ Spinal Cord Injury ____________
❑ Amputee ____________
❑ CVA ____________
❑ Muscular Dystrophy ____________
❑ Spinal Muscular Atrophy ____________
❑ Arthritis ____________
❑ Cerebellar Ataxia ____________
❑ Neuropathy ____________
❑ Traumatic Brain Injury ____________
❑ Autism ____________
❑ Developmental Disability ____________
❑ Parkinson's ____________
❑ Cerebral Palsy ____________
❑ MSA ____________
❑ Pressure Ulcer ____________
❑ Other: ____________

Current impairment requiring treatment: (please check at least one)

❑ Aphasia
❑ Apraxia
❑ Ataxia
❑ Cognitive decline
❑ Dementia
❑ Diplegia
❑ Dysarthria
❑ Edema
❑ Gait abnormality
❑ Hearing impairment
❑ Hemiplegia
❑ Impaired Sensation
❑ Kyphosis
❑ Learning disability
❑ Mobility impairment
❑ Motor impairment
❑ Muscle weakness
❑ Non-vocal
❑ Paraparesis
❑ Paraplegia
❑ Postural abnormality
❑ Postural assymetries
❑ Pressure ulcer
❑ Quadriparesis
❑ Quadriplegia
❑ Scoliosis
❑ Spastic quadriplegia
❑ Other: ____________

I certify that I have examined the patient and that the services required above are medically necessary and will be furnished while the patient is under my care.

____________ Physician's Printed Name   ____________ Physician's Signature   ____________ Date

Address: ____________________ Phone: ____________

FAX: ____________ LIC: ____________ NPI: ____________

10/17/14