



OCCUPATIONAL THERAPY – BARRIER FREE DESIGN

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

Date: _____ Patient Name: _____

Gender: _____ Date of Birth: _____

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Medical Diagnosis: _____ ICD 10: _____ Onset Date: _____

OT Prescription for: (please select)

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Physician Order Frequency and Duration: _____

Physician's Name (Please Print): _____

License Number: _____ UPIN: _____ NPI#: _____

Office Telephone: _____ Office Fax: _____

Physician's Signature: _____