NYU Langone Health

OCCUPATIONAL THERAPY – BARRIER-FREE DESIGN

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

Date: ____________________ **Patient Name:** ____

Gender: □ CŜƳl·ſŜ □ a l·ſŜ **Date of Birth:**_______ ψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψ

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tNJλƳl·NJè LƴǎdzNJl·ƴǾŜY ____________________________ψψψψ tƨſλǾè bdzƳōŜNJY ___________________________
{ŜǾƨƴŘl·NJè LƴǎdzNJl·ƴǾŜY ___________________ψψψψψψ______ tƨſλǾè bdzƳōŜNJY ___________________________
LƴǎdzNJŜŘ bl·ƳŜY ____

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Medical Diagnosis: __________________________ *ICD 10*: __________________ *Onset Date:* ________

OT Prescription for: **(please select)**
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Physician Order Frequency and Duration: ___________________________

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Physician's Name (Please Print): ____
License Number: _____________**UPIN:** _______________________**NPI#:** __________________
Office Telephone: ó______ú________π_____________**Office Fax:** ó____ú_______ψ πψψψψψψψψψψψ

Physician's Signature:____