St. Clair County Community Mental Health Authority
3111 Electric Ave. ◆ Port Huron, MI 48060 ◆ (810) 985-8900

Prescription for OT Services

PART I- OT Assessment Request

Name: _____ Case #: _____ Date of Request: _____

Requested By: _____ _____
Print Name Requested by Signature/Credentials

Caseholder Name: _____ _____
Print Name Caseholder Signature/Credentials

Supervisor Approval: _____ _____
Print Name Supervisor Signature/Credentials

Assessment Ordered: ☐ OT Assessment ☐ OT Assessment- *Unsafe Eating Behaviors

Diagnosis: _____

Rational for Assessment:

Physician Signature: _____ Effective Date: _____
Physician Signature/Credentials Through One Year of Physician Signature/Date

Physician Name: _____
Print Name

PART II- OT Treatment Request

Prescription for:

☐ OT Services ☐ Items

Description of service(s) or item(s) checked above:

*When Request is Related to Unsafe Eating- Select a Box Below

*☐ Requires Medical Attention *☐ Requires Behavioral Interventions ☐ Other: _____

Length of Treatment: ☐ 90 Days ☐ 6 Months ☐ One Year

Diagnosis:

Physician Signature: _____ Effective Date: _____
Physician Signature/Credentials Through One Year of Physician Signature/Date

Physician Name: _____
Print Name