Prescription for Therapy

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_

🗷 Evaluate and Treat **(Select one)**

**\_\_\_\_\_ Occupational Therapy**

**\_\_\_\_\_ Speech Therapy**

**Referring Physician** (Please Print): Dr.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify that these services are medically necessary and are authorized by me. I also certify that the patient’s medical condition is sufficiently stable to permit safe therapy as described herein.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_

Physician Signature