EMPOWER
PEDIATRIC THERAPY

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

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