Therapy Referral/Prescription Form

Patient Name ________________________________ **DOB** ____/____/_____
Diagnosis ____
Date of Onset ____
Precautions (if any) ____

Treatment Program

□ Evaluate & Treat

□ Developmental Stimulation
□ Balance/Coordination Training
□ Caregiver Training/Education
□ Neuromuscular Re-education
□ ROM/Strengthening
□ Gait/Mobility Training
□ Home Exercise Program
□ Therapeutic Activities
□ Other/Specify ____

Special Instructions/Precautions ________________________________
____
____
Frequency/Duration ____

Physician Signature ______________________________ **Date** _________

Our office will obtain **INSURANCE AUTHORIZATION** *on behalf of your patient*

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