PHYSICIAN RECOMMENDATIONS/ORDERS

Patient's Name: _____ DOB: _____

Patient's Address: _____

_____

Parent/Guardian: _____

Telephone: _____

Time period of services (dates should match Child's IEP): _____

ICD Code (Required): _____

Diagnosis and/or reason/need for ordered services:

_____

_____

Orders for Discipline and Treatment (Check all that apply):

- ☐ Speech Therapy
- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Other: _____

NOTE: Frequency and duration per Child's IEP.

The patient is under my care. I have authorized the services on this order and will periodically review the plan of care.

_____ _____

Physician's Name Physician's Signature Date

_____ _____

Street Address NPI and License No. (Required)

_____

City, State, Zip Code

_____

Telephone No.

Please sign and return as soon as possible. Child cannot receive service(s) until we receive this form.

Thank you.