PRESCRIPTION – TO BE COMPLETED BY PHYSICIAN
Please use most specified ICD-10 code available

Client Name: ______________________ Client Date of Birth: ___ - ___ - ___

Therapy Recommended:

	Physical Therapy
	Occupational Therapy
	Speech/Language Therapy
	Mental Health Services

	Evaluation Only
X	Evaluation and Treatment
	Psychological Testing

For Physician's Completion:

Client's Diagnosis/es:

Description	**ICD-10 Code**
______________________________	_______________
______________________________	_______________
______________________________	_______________
______________________________	_______________
______________________________	_______________

Physician Name (Printed): ____

Signature: ______________________________ Date: _____ - _____ - ______