lifebeyondbarriers
REHABILITATION GROUP

PRESCRIPTION FOR TREATMENT

Client Information:

Client Name: _____ Date of Birth: _____

Physician: _____ Physician NPI #: _____

Physician Phone: _____ Physician Fax: _____

Diagnosis: _____

Diagnosis ICD-10 Code(s): _____

Services:

	Service		Related Diagnosis/Code *(if different from above)*	Duration
☐	**Physical Therapy**	Evaluate and Treat		**___x/wk, _____ wks**
☐	**Occupational Therapy**	Evaluate and Treat		**___x/wk, _____ wks**
☐	**Speech Therapy**	Evaluate and Treat		**___x/wk, _____ wks**
☐	**Counseling/Social Work**	Evaluate and Treat		**___x/wk, _____ wks**
☐	**Aquatic Therapy**	Evaluate and Treat		**___x/wk, _____ wks**
☐	**Nutritional Counseling – Dietitian**	Evaluate and Treat		**___x/wk, _____ wks**
☐	**Personal Training/Wellness**	Evaluate and Treat		
☐	**Art Therapy Group/Counseling**			
☐	Other:			

New Referrals: Please forward demographics and most recent applicable office note with prescription.

Physician Signature: _____Date: _____

Thank you for your referral!

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