CI
Pediatric Therapy Centers

PRESCRIPTION – TO BE COMPLETED BY PHYSICIAN

Client Name:_____ Client Date of Birth:_____-_____-_____

Client's Diagnosis/es:

Description	**ICD-10 Code**
_____	_____
_____	_____
_____	_____
_____	_____

	Physical Therapy
	Occupational Therapy
	Speech/Language Therapy
	Aquatic Therapy
	Advance (Intensive) PT/OT/ST Program: 5x/week, Evaluation and Treatment

Therapy Recommended: (please check all that apply)

	Evaluation Only
	Evaluation and Treatment

Additional Comments or Concerns:

Please fax a prescription including **ICD 10 codes** to **608-509-9209**. Thank you!

Physician Name (Printed):_____

Physician Signature:_____ Date:_____-_____-_____