THE
PEDIATRIC MOVEMENT CENTER
EMPOWER :: ACHIEVE :: INSPIRE

Outpatient Therapy Prescription Form

Patient Name:____ DOB:_______________

Diagnosis:____

Surgical Procedure:____ Onset Date:__________

Precautions:____

☐ PHYSICAL THERAPY

☐ Evaluate and Treat

☐ Other ____

☐ OCCUPATIONAL THERAPY

☐ Evaluate and Treat

☐ Other____

☐ SPEECH THERAPY

☐ Evaluate and Treat

☐ Other____

☐ ADAPTIVE EQUIPMENT EVALUATION

☐ Equipment Needs____

Referring Physician Signature_____________________________________ Phone #____________________

Print Name____ Fax #________________________

Prescription expires in 90 days

Please fill out and return with a copy of demographics and insurance cards to The Pediatric Movement Center:

info@pmchag.com :: F (301) 739 - 7453

To schedule an evaluation please call (301) 739 – 5437