ABSOLUTE Pediatric THERAPY

Occupational, Physical and Speech Therapy

PRESCRIPTION/REFERRAL
PRIVATE PAY/INSURANCE

Referral (check all that apply) ☐ OT ☐ PT ☐ ST ☐ DT ☐ Treatment

Patient Name: _____ Insurance Company: _____

Insurance Policy #: _____ Group ID #: _____

Date Child Was Last Seen In Office: _____

Diagnosis as Related to Prescribed Therapy: _____

_____
_

Complete this block if this form is a prescription		
Occupational Therapy (OT)	**Physical Therapy (PT)**	**Speech Therapy (ST)**
_____Minutes per week	_____Minutes per week	_____Minutes per week
_____Duration (months)	_____Duration (months)	_____Duration (months)
☐ Therapy Not Medically Necessary	☐ Therapy Not Medically Necessary	☐ Therapy Not Medically Necessary

Other Information: _____

_____

Note:

_____ _____
Primary Care Physician (PCP) Name *(Please Print)* Provider ID Number/Taxonomy Code

_____ _____
Attending Physician Name *(Please Print)* Provider ID Number/Taxonomy Code

By signing as the PCP or Attending Physician, I hereby certify that I have carefully reviewed each element of the therapy treatment plan, that the goals are reasonable and appropriate for this patient, and in the event that this prescription is for a continuing plan I have reviewed the patients progress and adjusted the plan for his or her meeting or failure to meet the plan goals.

_____ _____
Physician Signature *(PCP or attending Physician)* Date

Return To (name of provider): Absolute Pediatrics Fax Number: 479-553-7954