PRESCRIPTION FOR MENTAL HEALTH THERAPY SERVICES

Patient's Name: _____________________________ Patient's Date of birth: ____________________

Name of Physician: _____________________________ Physician's NPI #: ____________________

I certify that the above named individual is eligible for mental health therapy services through Children's Therapy Network.

Diagnosis/Presenting Problems: ____

Signature of Physician: _____________________________ Date: ____________________

In lieu of this form, Children's Therapy Network will accept a signed order for mental health therapy services in forms determined appropriate by the treating physician. Prescriptions may be faxed to (608) 819-6825.