



**PRESCRIPTION FOR SPEECH AND LANGUAGE 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 speech and language therapy services in forms determined appropriate by the treating physician. Prescriptions may be faxed to (608) 819-6825.**