



PRESCRIPTION FOR PHYSICAL 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 physical 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 physical therapy services in forms determined appropriate by the treating physician. Prescriptions may be faxed to (608) 819-6825.