Early childhood specialists
LosNinos.com
1-877-LOS-NINOS

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Prescription for Therapy Services

Child's name: ____ **DOB:** ____/____/____

* Have therapist treat the child as follow:

Physical Therapy	**Start Date**
	____/____/____
Frequency/Duration	

Family Training for PT	**Start Date**
	____/____/____
Frequency/Duration	

Occupational Therapy	**Start Date**
	____/____/____
Frequency/Duration	

Family Training for OT	**Start Date**
	____/____/____
Frequency/Duration	

Medical Clearance

Yes ______ **No**_______ **Reason** ____________________________________

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***Please note contra-indications or precautions:**

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______________________________ ____________________ ____/____/____

Physician's Signature **ID #** **Date**

** **Please note that this <u>prescription is not valid if it is not dated and stamped</u>.** **