Manhattan Star Academy

A member of the YAI network.

Prescription for Therapy

Re: _____ DOB: _____

The above named child has been identified as a child with a disability and eligible for therapeutic services.

ICD-9 Code(s): _____

Diagnosis/Purpose of Treatment:

_____

_____

_____

☐ Occupational Therapy From: _____ To:_____

☐ Physical Therapy From: _____To: _____

Physician's Comments/ Precautions:

_____

_____

_____

_____ _____

Physician's Signature Physician's License # and/or NPI #

Date: _____

Name: _____

Address: _____

Phone: _____