Physician Prescription

Keystone Pediatric Therapy PLLC
2720 Virginia Parkway, Suite 300, McKinney TX 75071

Clinic Phone: (972) 548-1990 **Clinic FAX: (972) 548-1981**

Instructions: 1. Complete form; 2. Fax form to number indicated above.

If you have any questions, please call the number listed above

Patient Name: _____ **Date of Birth:** _____

Parent/Guardian Name: _____ **Home Phone:** _____

Address: _____ **Work Phone:** _____

City/State/Zip: _____ **Cell Phone:** _____

Diagnosis: _____ **ICD-9 Code:** _____

Special Precautions/Instructions: _____

OCCUPATIONAL THERAPY:

☐Evaluation

☐Treatment

Frequency/Duration: _____

SPEECH THERAPY (Language Only)**:**

☐ Evaluation

☐Treatment

Frequency/Duration: _____

FEEDING THERAPY: (May include ST, OT)**:**

☐Feeding Evaluation

☐Feeding Treatment

☐*Neuromuscular Electrical Stimulation*

☐*Other*

Frequency/Duration: _____

I hereby certify these services as medically necessary for the patient's plan of care.

Physician Signature: _____ **Date:** _____ **Time:** _____
(Original Required – Stamped Not Acceptable)

Printed Name: _____ **UPIN/NPI#:** _____

Address: _____ **Office Phone #:** _____

City/State/Zip: _____ **Fax #:** _____