Advance Therapy
Occupational, Physical, and
Speech Language Therapy for Children
"Helping children shine!"

PHYSICIAN'S ORDER FORM

Patient's Name:_____DOB:_____

Diagnosis (if any/suspected):

_____

Order for: (check all that apply)

☐ Occupational Therapy ☐ Speech Language Therapy ☐ Physical Therapy

☐ Evaluation and Treatment

____Days per week for_____weeks

____As needed, per therapist recommendation

Comments:

Statement of Medical Necessity:

Physician's Name (print full name):_____

Physician's Signature:_____ Date:_____

Clinic Name and
Address:_____

Physician's NPI Number: _____

Physician's Phone Number:_____ Fax:_____

Thank you for choosing Advance Therapy!

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