



FIELDSTONE FARM

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## Prescription Form

(Please complete all requested information)

**Barbara Davis, P.T. Allison Evans, O.T. & Deborah Sords, P.T.**

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### **PHYSICIAN'S PRESCRIPTION**

Client's Name: \_\_\_\_\_

Phone: \_\_\_\_\_

#### **Prescription for Rehabilitation Services**

Prescription, where appropriate for evaluation and treatment by a Physical, Occupational and/or Speech Therapist.

Diagnosis: \_\_\_\_\_

Treatment: \_\_\_\_\_

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Recommended Frequency: \_\_\_\_\_

Precautions: \_\_\_\_\_

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Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please print, type or stamp

Physicians Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

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Phone: \_\_\_\_\_

Updated: 01.15.10