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-10 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: ________________________________

For Medicaid Patients:

Date of last office visit: ______________________ __

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

Physician Signature:		**Date:**		**Time:**	
Printed Name:		**UPIN/NPI#:**			
Address:		**Office Phone#:**			
City/State/Zip:		**FAX#**			