Family Achievement Center Inc.

Providing services in:
Physical Therapy
Occupational Therapy
Speech/Language Pathology
Aquatic Therapy
Special Therapy Programs

PRESCRIPTION / PHYSICIAN'S ORDER FORM

Patient's Name: _____DOB: _____
Last First MI

Diagnosis: (1)_____(2)_____(3)_____(4)_____

Insurance: _____

□ **Physical Therapy** □ **Occupational Therapy** □ **Speech Therapy**

_____Evaluate and Treat

_____Days per week for _____ weeks

_____ As needed, per therapist recommendation

Comments/Specific instructions:

Statement of Medical Necessity:

Physician's Name: (Print) _____

Physician's Signature: _____Date:_____

Physician's Address: _____

Physician's Phone Number: (_____)_____ Fax: (_____)_____

Please fax referral form to FAC at **651-738-9889** to expedite your patient's prior authorization and scheduling process.

THANK YOU FOR CHOOSING FAMILY ACHIEVEMENT CENTER!

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