The Children's Therapy Center, Inc.

Please complete a Prescription for these services:

Date:_____ Patient Name: _____Date of Birth:_____

Parent/Guardian:_____ Phone**:**_____

Occupational Therapy Prescription

OT evaluation and treatment

- ☐ F84.0 – Autism
- ☐ R27.8 – Dyspraxia, hypotonia, lack of coordination
- ☐ M62.81 Muscle weakness
- ☐ F90.1 ADHD predominately hyperactive
- ☐ F90.0 ADD
- ☐ F90.9 ADHD not-specified
- ☐ F90.2 ADHD Combined type
- ☐ F41.1 Generalized Anxiety Disorder
- ☐ Other DX- _____

OT evaluation and treatment for feeding

(Please include any precautions, or previous testing regarding feeding)

- ☐ R63.30 Feeding difficulties, unspecified
- ☐ R63.31 Pediatric feeding disorder, acute
- ☐ R63.32 Pediatric feeding disorder, chronic

Speech Therapy Prescription

Speech evaluation and treatment

(Initial evaluation for client)

- ☐ F84.0 – Autism
- ☐ F80.0 – Phonological/Speech Sound Disorder/Articulation/Lisping
- ☐ F80.1 = Expressive Language Disorder
- ☐ F80.2 – Mixed receptive-expressive language disorder
- ☐ Other DX- _____

Speech Myofunctional/Oral Motor Therapy

(please include any diagnosis, e.g. Tongue Tie or Lip Tie)

- ☐ Q38.0 – Congenital malformation of Lip
- ☐ Q38.1 – Ankyloglossia (Tongue Tie)
- ☐ Other - _____

Physician's Signature: _____

Physician's Name: _____Date: _____
(Please Print)

Return by fax to:

Fax: 281 480-5691

310 Odyssey Drive - Webster, TX 77598 - Phone: 281 480-5648