

Eagle Point Nursing & Rehab Center

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Clinton, IA 52732

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OUTPATIENT THERAPY PHYSICIAN PRESCRIPTION

Patient Name: _____

Patient
Address: _____

_____ Patient Phone #: _____

Diagnosis: _____ Onset Date: _____

Precautions: None Specified Precautions: _____

Evaluation & Treatment: Physical Therapy Speech-Language Pathology
 Occupational Therapy Other

Frequency: _____ X per week Duration: _____ Weeks

Requesting Therapist: _____ Date: _____

Requesting Physician: _____ (Please Print)

Physician Address: _____

Physician Phone: _____ Fax: _____

Physician Email Address: _____

Physician Signature: _____ Date: _____

Specified Treatment Referred By: _____

Family/POA Has Been Notified

Family/POA Has Approved Evaluation & Treatment

WE ARE FAMILY SERVING FAMILIES.®

