PHYSICIAN ORDER

Client Data
Name:__________________________________ Date of Birth:______________
Address:______________________________________________________________
Primary Diagnosis:______________________________________________________
Secondary Diagnosis:____________________________________________________

Does this patient have any precautions for participating in occupational therapy?
___Yes  ___No

If yes, please specify precautions:__________________________________________

Rx:

Physician's Name:______________________________ License #:______________
(please print)

Physician's Signature:____________________________ Date:______________

The Pediatric Occupational Therapy Clinic at Samuel Merritt University was established for student training and to provide free services to the surrounding community. By completing this prescription form, the physician is NOT indicating that the named child requires occupational therapy. Use of this form informs the physician of services being provided to the named child and an opportunity to communicate any precaution that should be considered while the child is in the clinic.