



"Creating A Better Tomorrow, Today"

PHYSICIAN ORDER / PRESCRIPTION

Patient Information:

Patient Name: _____

Patient Address: _____

Medicare No. (HICN) : _____

Clinical Information

Prescribed Date: _____ Length of Need: _____

Diagnosis & ICD-9 Codes: _____

MR Diagnosis: No Yes, if yes, provide Diagnosis Code: _____

Prognosis: _____

Equipment Prescribed (Must be item specific, list all items)

Please indicate if you have received a copy of the Speech-Language Pathologist's completed Augmentative Communication Evaluation for the subject patient. (Required by Medicare)

Yes No

Physician's Information

Physician's Name: _____ NPI#: _____

UPIN# _____ Phone # (____) _____

Address: _____

Physicians Signature: _____ Date: _____

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