C.H.T.Services,Inc.

2901 Campus Road, Brooklyn, NY 11210
Phone: (718)874-6226 Ext. 101. **Fax:** (718)874-0041
www: chtservices.com

Prescription for Therapy Services

Child's name:_____ **DOB:** ____/____/____

* **Have therapist treat the child as follow:**

Physical Therapy	**Start Date**
	____/____/____
Frequency/Duration	
Family Training for PT	**Start Date**
	____/____/____
Frequency/Duration	
Occupational Therapy	**Start Date**
	____/____/____
Frequency/Duration	
Family Training for OT	**Date**
	____/____/____
Frequency/Duration	

Medical Clearance
Yes _____ **No**_____ **Reason** _____

_____

_____

_____

*__Please note contra-indications or precautions:__

_____

_____

_____

_____ _____ ____/____/____
Physician's Signature **ID #** **Date**

** Please note that this prescription is not valid if it is not dated and stamped. **