THERAPEUTIC SOLUTIONS OF NC

Physician Order Request Form
For Occupational Therapy Service

PLEASE INCLUDE A COPY OF THE CLIENT'S LAST NOTE

Client Name: _____

Medical and Treatment Dx: _____

Client Phone: _____ **DOB:** _____

Client Address: _____

Onset Date: _____

Primary Insurance and Number: _____

Secondary Insurance and Number: _____

Physician: _____

Office Address: _____

Office Phone: _____ **Office FAX:** _____

Email Address: _____

Physician NPI #: _____

This client would benefit from the following therapy services:

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☐ **Occupational Therapy**

Reason for Request: _____

Treatment to include:

☐ **Evaluation** ☐ **OT-Mental Health Services**

☐ **Counseling Services** ☐ **OT-Low Vision**

Other: _____

Therapist:_____ **Signature:** _____

PLEASE INCLUDE A COPY OF THE CLIENT'S LAST NOTE

X **Physician Signature:** _____ **Date:** _____

Please sign, date and toll free fax to: 855-497-8443

100 Parkway Office Court, Suite 202, Cary, NC 27518 –- Office: 919-239-4805 // Toll Free FAX: 855-497-8443
therapeuticsolutionsofnc.com