**White Plains Public Schools**

EDUCATION HOUSE

FIVE HOMESIDE LANE

WHITE PLAINS, NEW YORK  10605

(914) 422-2037 phone

(914) 422-2311 fax

**Occupational and Physical Therapy Physician Order**

**20\_\_/\_\_ School Year**

|  |  |  |
| --- | --- | --- |
| Child’s Name: | «StudentFirstName» «StudentLastName» | DOB |

Medical Diagnosis as Related to Prescribed Treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ICD-9 Code(s) or Diagnosis Statement**

\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I recommend the above listed student receive the following services:

**Effective from 9/1/\_\_\_\_ to 9/1/\_\_\_\_**

**Purpose of Treatment:**

|  |  |  |  |
| --- | --- | --- | --- |
| **🞎 Occupational Therapy**   |  |  | | --- | --- | | **🞎 Physical Therapy**  \_\_\_I\_\_\_\_ Minutes  \_\_\_G\_\_\_ Minutes | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |   \_\_\_I \_\_\_ Minutes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_G\_\_\_ Minutes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

**🞎**  **Speech / Language Therapy**

\_\_\_I \_\_\_ Minutes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_G\_\_\_ minutes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Contact Information:

Place Stamp Here

Physician/Physician Asst./Nurse Practitioner Name Provider ID Number/NPI

*(****please Print****)*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician/Physician Asst./Nurse Practitioner Signature Date