BOSTON A+ BILITY CENTER

MAKING FUN AND FUNCTION GO HAND IN HAND

OUTPATIENT THERAPY PRESCRIPTION

PATIENT'S NAME: _____ DATE OF BIRTH: _____

INSURANCE PROVIDER: _____

DIAGNOSIS (if applicable): _____

REFERRAL TO: Boston Ability Center (Tax ID: 06-1827046)

SERVICE(S) REQUIRED:

- ☐ Occupational Therapy
- ☐ Physical Therapy
- ☐ Speech/Language Therapy
- ☐ Feeding Therapy (occupational therapy and speech therapy)

START DATE: _____

INSTRUCTIONS: Evaluate and treat

_____ _____

Physician's Signature *Date*

_____ _____

Physician's Name *Physician's NPI #*

Please fax signed prescription to the Boston Ability Center at: 781-239-0102

49 WALNUT PARK, BUILDING 3, WELLESLEY HILLS, MA 02481
10 TECH CIRCLE, NATICK, MA 01760
781.239.0100 | BostonAbilityCenter.com