Children's Therapy Network LLC

PRESCRIPTION FOR MENTAL HEALTH THERAPY SERVICES

Patient's Name: _____ Patient's Date of birth: _____

Name of Physician: _____ Physician's NPI #: _____

I certify that the above named individual is eligible for mental health therapy services through Children's Therapy Network.

Diagnosis/Presenting Problems: _____

Signature of Physician: _____ Date: _____

In lieu of this form, Children's Therapy Network will accept a signed order for mental health therapy services in forms determined appropriate by the treating physician. Prescriptions may be faxed to (608) 819-6825.