# LifeStriders

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Waukesha, WI 53188

**Physician's Order for Individual Counseling/Group Therapy/Occupational Therapy**
**(Must Be Signed by Treating Medical Specialist)**

**Client:**_____ **has been deemed eligible for:**

_____Occupational therapy services based on evaluation

_____Individual Counseling and/or Group Therapy services based on evaluation

Client Name: _____ Birthdate: _____

Parent/Guardian _____

Address: _____ Phone: _____

**Physician:** Please complete the items below. The form may be returned to your client, or to LifeStriders via fax or email. If clinics own prescription form is required, please be sure to include it in the returned packet. Thank you!

_____ Please provide Occupational Therapy services as needed
_____Please provide Individual Counseling/Group Therapy services as needed

**Medical Diagnosis/Description of Disability:**_____
_____

**Precautions/Contraindications:**_____
_____

**Additional Comments:**_____
_____

This referral form will be valid for **1 year**, unless services are terminated, there is a change in the above mentioned participants medical status, or an updated order is necessary.

Physician's Name: _____

Phone: _____

Address: _____

Physician's Signature: _____ Date: _____