



**MYHEROES, LLC.**  
OVERCOMING OBSTACLES, ONE HOOF AT A TIME

**Therapy Prescription**

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Physician Name:** \_\_\_\_\_ **NPI:** \_\_\_\_\_

**Physician Phone Number:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Follow up date:** \_\_\_\_\_

**Diagnosis (ICD-10 codes):** \_\_\_\_\_

**Precautions:** \_\_\_\_\_

**Order for:**

Physical Therapy     Occupational Therapy     Speech Language Pathology

**Prescription to:**    Evaluate and Treat    Re-evaluate

**Frequency:** \_\_\_\_\_ **Duration:** \_\_\_\_\_

**Goals:**

Improve ROM     Improve Strength     Improve Mobility     Improve Function

Other: \_\_\_\_\_

\_\_\_\_\_  
**Physician Signature**

\_\_\_\_\_  
**Date**

**Physician, please fax this referral slip to (888) 551-6210. Thank you!**