Children's Hospital of The King's Daughters Health System

Augmentative Communication Prescription

Patient Name: _____ D.O.B: _____ Date: _____

Parent's Name: _____ Phone Number: _____

Referring Physician: _____ Office Number: _____

- ☐ Augmentative Communication Evaluation with Speech and Occupational Therapy
- ☐ Assistive Technology Evaluation with Speech and Occupational Therapy

Medical Diagnosis: _____ICD 10 Code: _____

Special Instructions/Precautions: _____

_____

Physician Signature: _____ Date: _____ Time:_____

FAX ALL THERAPY PRESCRIPTIONS TO: 757-668-7389