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

Occupational Therapy Prescription

Patient Name: _____D.O.B: _____Date:_____

Parent's Name: _____Phone Number: _____

Referring Physician: _____ Office Number: _____

Medical Diagnoses: _____

- ☐ **Occupational Therapy Evaluate and Treat as Necessary**
  - ☐ **Special Instructions/Other: _____**
    _____
  - ☐ **Specific Occupational Therapy Modalities Indicated:**
    _____

Physician Signature: _____Date:_____ Time: _____

Preferred Therapy Location:

- ☐ **Oyster Point Health Center**
  Newport News, VA
- ☐ **Kempsville Health Center**
  Norfolk, VA
- ☐ **Oakbrooke Health Center**
  Chesapeake, VA
- ☐ **Princess Anne Health Center**
  Virginia Beach, VA
- ☐ **Harbor View Health Center**
  Suffolk, VA
- ☐ **General Booth Health Center**
  Virginia Beach, VA
- ☐ **CHKD Main Building**
  Norfolk, VA
- ☐ **CHKD Medical Tower**
  Norfolk, VA
- ☐ **CHKD Burnett's Way**
  Downtown Suffolk, VA

FAX ALL THERAPY PRESCRIPTIONS TO: 757-668-7389