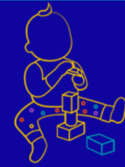
THERAPY PRESCRIPTION



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CHALLENGING MYTHS - CHANGING LIVES

Thank you for referring your patient to our office. In an effort to provide the best service possible, we ask that you thoroughly complete this form and fax it back to 1-702-549-7717

Dr. ______________________________

Patient: ______________________________ **D.O.B:** ______________

DIAGNOSIS:

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CONCERNS:

- ☐ Speech & Feeding
- ☐ Evaluation
- ☐ Treatment 12 months
- ☐ Caregiver Training 12 months
- ☐ Refill x1

DR.'S REMARKS AND ADDITIONAL INFORMATION:

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DR.'S SIGNATURE

X ______________________________ **Date:** ______________

NPI: ______________________________

not too little speech therapy, llc
Phone: 702-527-3142 Fax: 1-702-549-7717 Email: contact@nottoolittle.com