

Words+, Inc.

Physician Prescription

Patient Name: _____

Patient Address: _____

Clinical Information:

Primary Diagnosis: _____ **ICD-9:** _____

Secondary Diagnosis: _____ **ICD-9:** _____

Duration of Need: _____

Equipment Requested:

Statement from Physician:

I have reviewed a copy and agree with the Speech Pathologist Report for a Communication Device and Accessories recommended for the patient.

The prescribed Speech Generating Device and accessories are medically necessary for the patient in order for him/her to achieve the functional communication goals stated within the Speech Pathologist Report.

Physician Information:

Physician Name (printed) _____

UPIN # _____ **NPI#** _____

Address: _____

Phone #: _____ **Fax#:** _____

Physician Signature: _____

Date: _____