PHYSICIAN PRESCRIPTION

tobii dynavox

Patient Information ***Order Request Date:*** _____

Patient Name: _____ Date of birth: _____

Insurance ID: _____ Address: _____

Clinical information

Medical Diagnosis: _____

Communication Diagnosis: _____

Length of Need: Lifetime ☐ Other: _____

Prognosis: Good with use of Speech Generating Device ☐ Other: _____

Date of last Face-to-face visit (must be within last 6 months): _____

Equipment Prescribed

Equipment Description	Quantity

Mount needed: (circle one) Yes NO

Physician Information:

I have reviewed a copy of the Speech Language Pathologist's completed communication evaluation for the above patient and agree with the recommendation for the listed equipment. The prescribed device and accessories are necessary to achieve the functional communication goals for this patient as noted in the SLP's treatment plan.

Physician's Printed Name: _____ NPI: _____

Medicaid ID: _____ Phone: _____

Address: _____

Physician Signature: _____ ***Date:*** _____

Signature/Date stamps are not permitted