



Advanced Recovery Rehabilitation Center
4419 Van Nuys Blvd. Suite 412
Sherman Oaks, CA 91403
TEL: 818-386-1231
FAX: 818-386-0483
www.advancedrecovery.org

PRESCRIPTION FORM

Patient: _____

Diagnosis: _____

Precautions: _____

Evaluations and treatments are provided by a Licensed Speech-Language Pathologist:

- Speech Pathology evaluation**
- Constraint Induced Aphasia Therapy (CIAT)**
- Other:** _____

Frequency & duration: 5 days/week for up to 4 hrs a day x 3 weeks

- THIS PATIENT HAS BEEN MEDICALLY CLEARED TO PARTICIPATE IN CIAT**
- CONTACT ME PRIOR TO THE PATIENT PARTICIPATING IN CIAT**

Physician Signature: _____ **Date:** _____

Physician Name (please print) with UPIN # _____

Ph. No. _____ **Fax No.** _____