Maryland Therapeutic Riding
1141 Sunrise Beach Road
Crownsville, MD 21032
Phone: 410.923.6800
Fax: 410.923.1432
www.HorsesThatHeal.org

Date Received_____
(office use only)

Physician Prescription Form

Submit with Application Packet

Patient Full Name:_____ **Date of Birth:**_____

Patient Address:_____

Primary Dx:_____ **ICD 10 Code:**_____

Secondary Dx:_____ **ICD 10 Code:**_____

(Please provide BOTH diagnosis and ICD 10 code- incomplete forms will be returned)

Please indicate recommended service: Physical Therapy and/or Occupational Therapy and/or Speech

Evaluate and treat, to include hippotherapy as a treatment tool. Recommended frequency: Treatment as needed based on therapist evaluation.

This prescription will be good for one year (12 months) from date of Physicians Signature

Physician's Name:_____

License Number:_____ **Stamp Address Here:**

Address:_____

City, State:_____

Zip Code:_____

Telephone:_____

Physician's Signature:_____ **Date:**_____