

# REQUEST FOR PHYSICIAN RX

Date\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

To:	From:
Regarding Patient:	Dx:

To maximize this patients recovery and avoid further impairment I recommend the patient named above receive the item(s) stated:

Item: \_\_\_\_\_

Reason: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When:       Immediately       Other:

(To be completed by MD)	
<input type="checkbox"/> I concur with the above recommendations	<input type="checkbox"/> Other:
Name of MD_____	Date:_____
Signature of MD_____	

Please complete and **fax back** to STAR at (909) **279-5577**. Thank you.

