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THERAPY PRESCRIPTION FOR EDUCATIONAL NEEDS

PATIENT’S NAME:       DATE OF BIRTH:

SCHOOL:       PRESCRIPTION DATE:

RECOMMENDATIONS

|  |  |  |
| --- | --- | --- |
| OCCUPATIONAL THERAPY |  | PHYSICAL THERAPY |
| Evaluation only |  | Evaluation only |
| Evaluation/Treatment |  | Evaluation/Treatment |
| Self- Care |  | Exercise |
| Developmental Training |  | Gross Motor Skill Training |
| ROM/ Strengthening |  | Gait and Transfer Training |
| Motor Coordination Training |  | Seat and Positioning |
| Visual – Motor Training |  | Adapted Equipment /Splints |
| Classroom consultation |  | Classroom Consultation |

*Frequency Of Treatment To Be Determined By The IEP*

**THERAPISTS:**

Signed/     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed/     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHYSICIAN:**

(Signature) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Address) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Phone) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (FAX) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*PLEASE RETURN SIGNED DOCUMENT TO THE ADDRESS OR FAX NUMBER ABOVE*