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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*