UIC

PHYSICAL/SPEECH/OCCUPATIONAL THERAPY PLAN

DIVISION OF SPECIALIZED CARE FOR CHILDREN

Date_____

TO: _____

Child's Name_____

DSCC Case No._____

Address_____

City_____ Zip_____

County_____ Birthdate_____

PLEASE RETURN COPY TO:

Parents/Guardian_____

Phone No._____

An evaluation to develop a plan of therapy was recommended by Dr. _____

Please complete this form indicating your proposed plan and return it with a copy of your evaluation report.

Please indicate your therapy recommendations:

Therapy type	OT ☐	PT ☐	ST ☐
Sessions per week			
Minutes per session			
For how many months			

Condition to be treated by therapy:_____

How does this condition impair the child? _____

Overall treatment goals of therapy (please relate to impairments): _____

Specific treatment objectives (please limit to 6 month period and state in measurable terms):_____

Are these gains greater than those expected from maturation alone? _____

Date of assessment: _____

Name of therapist: _____

Address: _____

_____

Physician's Signature

Clear Form