



**PHYSICAL/SPEECH/OCCUPATIONAL  
THERAPY PLAN**

**DIVISION OF SPECIALIZED CARE  
FOR CHILDREN**

TO: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date \_\_\_\_\_  
Child's Name \_\_\_\_\_  
DSCC Case No. \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ Zip \_\_\_\_\_  
County \_\_\_\_\_ Birthdate \_\_\_\_\_  
Parents/Guardian \_\_\_\_\_  
Phone No. \_\_\_\_\_

PLEASE RETURN COPY TO:

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 <input type="checkbox"/>	PT <input type="checkbox"/>	ST <input type="checkbox"/>
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

