UIC

PHYSICAL/SPEECH/OCCUPATIONAL THERAPY PLAN (05.27)

DIVISION OF SPECIALIZED CARE FOR CHILDREN

Date_____

TO: _____

Patient's Name_____

DSCC Case No._____

Address_____

City_____ Zip_____

PLEASE RETURN COPY TO:

County_____ Birthdate_____

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	PT ☐	OT ☐	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

Start Over