

**PHYSICAL/SPEECH/OCCUPATIONAL THERAPY PLAN**

Date \_\_\_\_\_

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

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