SPECIALIZED CARE FOR CHILDREN

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 ☐	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