



South Lyon Community Schools

Special Services Office • 62500-B West Nine Mile Rd. • South Lyon, MI 48178 • (248) 573-8220 • Fax (248) 437-8438
Susan Toth, Director of Special Education

Physical and Occupational Therapy Prescription

Student Full Name: _____ Date of Birth: _____

Diagnosis: _____

School/Location: _____ Therapist Name: _____

Physical Therapy

- ____ Balance Activities
- ____ Coordination, Dexterity & Bilateral Motor Activities
- ____ Developmental Activities
- ____ Mobility, Gait Training
- ____ Navigational Skills
- ____ Orthosis; Wheelchair Eval
- ____ Range of Motion/Stretching
- ____ Strengthening
- ____ Adaptive Equipment

Occupational Therapy

- ____ Fine Motor Activities
- ____ Activities of Daily Living Skills
- ____ Strengthening
- ____ Visual/Perceptual Activities
- ____ Sensory Motor Activities:
 - ____ Sensory Integration
- ____ Feeding Skills
- ____ UE Range of Motion/Stretching
- ____ Splinting/Adaptive Equipment

Other: _____

Frequency: _____

Precautions: _____

****Physician's Recommendations to evaluate and treat: Occupational Therapy Physical Therapy**

Physician's Printed Contact Information:

Physician Full Name: _____

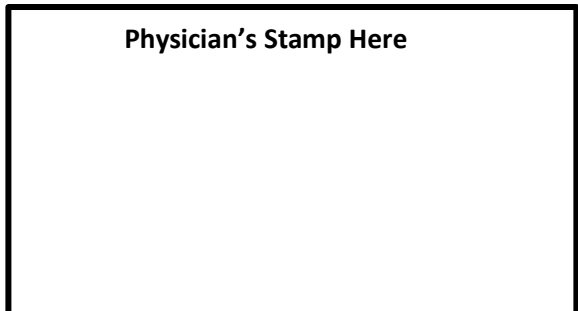
Address: _____

City, State, Zip: _____

Phone Number: _____

National Provider Identifier (NPI) _____

Medicaid Enrolled Provider Number: (only if diff. than NPI) _____



Signature of Physician (Including Title (MD, DO, PA, CNP, etc.))

Date of Signature

*****This prescription is valid for twelve (12) months from Date of Signature.*****