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:_____

Physician's Stamp Here

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.*****