

Wayne County Physician's Prescription Form

Direct therapy services provided in the school setting are based on educational relevance and need and are determined by the Individualized Education Planning Team (IEPT). Please note that in order to receive occupational, orientation & mobility, or physical therapy services, students must have current documentation of a medically based condition.

Student's Name: _____ Date of Birth: _____

Attending District: _____ UIC #: _____

DIAGNOSIS (required): _____

Does this diagnosis result in a life-long disability? YES NO

Student's Medication(s)/Precaution(s)/Restriction(s)/Allergies: _____

Physical Therapy Recommendations:

- | | |
|---|--|
| <input type="checkbox"/> Evaluate & Treat per educational goals | <input type="checkbox"/> Balance and Coordination |
| <input type="checkbox"/> Muscle Strengthening | <input type="checkbox"/> Gait Training and Mobility |
| <input type="checkbox"/> Range of Motion | <input type="checkbox"/> Grosse Motor Skills |
| <input type="checkbox"/> Positioning | <input type="checkbox"/> Consult Services – classroom staff and caregivers |
| <input type="checkbox"/> Other: _____ | |

Occupational Therapy Recommendations:

- | | |
|--|--|
| <input type="checkbox"/> Evaluate & Treat per educational goals | <input type="checkbox"/> Activities of Daily Living |
| <input type="checkbox"/> Muscle Strengthening | <input type="checkbox"/> Consult Services – classroom staff and caregivers |
| <input type="checkbox"/> Range of Motion | <input type="checkbox"/> Visual Perception Skills |
| <input type="checkbox"/> Fine Motor Skills & Manipulation Skills | <input type="checkbox"/> Oral Motor Training to prepare for or improve oral Sensory Motor Skills in feeding/drinking |
| <input type="checkbox"/> Monitor Equipment Needs | |

Orientation & Mobility Recommendations: _____

This prescription covers school-based therapy for one year from the signature date.

Please note that ALL information MUST be filled out in order to process this prescription. A physician, physician assistant, or nurse practitioner may sign this form. Stamped signatures are invalid for school-based services.

Physician Signature and Credentials: _____ Date: _____

PRINT Physician's Name: _____ NPI#: _____

Address: _____

Phone #: _____ Fax #: _____

Please return the form to: _____