



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: _____

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

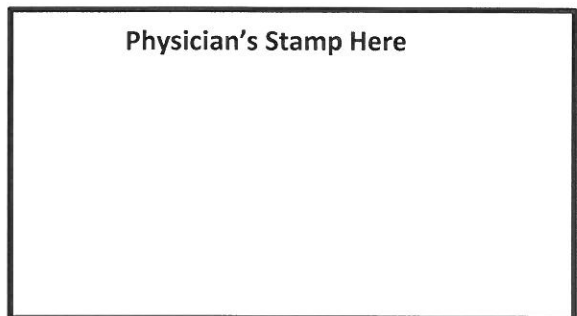
Physician's Printed Contact Information:

Physician Full Name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____



Signature of Physician

Date of Signature

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