WAYNE RESA Leading... Learning for All | SERVICE LEADERSHIP COLLABORATION EXCELLENCE

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:

- ☐**Evaluate & Treat per educational goals**
- ☐**Muscle Strengthening**
- ☐**Range of Motion**
- ☐**Positioning**
- ☐**Other: _____**
- ☐**Balance and Coordination**
- ☐**Gait Training and Mobility**
- ☐**Grosse Motor Skills**
- ☐**Consult Services – classroom staff and caregivers**

Occupational Therapy Recommendations:

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

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: _____