Pediatric Therapy Services

Occupational Therapy • Physical Therapy • Speech-Language Pathology

Name: ____________________________ Date: ____________________________

Diagnosis: ____________________________ Onset date: ____________________________

Treatment plan [check appropriate item(s)]

_____ Evaluate and treat

_____ Neurodevelopmental evaluation

_____ Neurodevelopmental treatment

_____ Speech and language evaluation and treatment

_____ Feeding evaluation and treatment

_____ Orthopedic evaluation and treatment

_____ Gait evaluation and treatment

Precautions/remarks:

________________________________________________

________________________________________________

________________________________________________

Contraindications:

________________________________________________

Physician name: ____________________________

Physician signature: ____________________________

Date: ____________________________