

PHYSICIAN'S PRESCRIPTION

Client's Name: _____ DOB: _____

Diagnosis: _____ **Date of Onset** _____

Please check all applicable diagnoses. If more than one diagnosis applies, please number in order of importance:

- | | |
|---|--|
| <input type="checkbox"/> Apraxia/ Dyspraxia (728.9) | <input type="checkbox"/> Feeding Disorder Infancy/Early Childhood (307.59) |
| <input type="checkbox"/> Attention Deficit Disorder/ combined type (314.01) | <input type="checkbox"/> Hyperkinesia with Developmental Delay (314.1) |
| <input type="checkbox"/> Attention Deficit Disorder/ hyperactivity (315.8) | <input type="checkbox"/> Hypotonia (728.9) |
| <input type="checkbox"/> Attention Deficit Disorder/ inattentive type(314.00) | <input type="checkbox"/> Infantile Cerebral Palsy (343.9) |
| <input type="checkbox"/> Cerebellar Ataxia (334.3) | <input type="checkbox"/> Infantile Spinal Muscular Atrophy (335.0) |
| <input type="checkbox"/> Cerebral Palsy: Spastic Diplegia ((343.0) | <input type="checkbox"/> Lack of Coordination (781.3) |
| <input type="checkbox"/> Cerebral Palsy: Spastic Hemiplegia (343.1) | <input type="checkbox"/> Mixed Developmental Disorder (315.8) |
| <input type="checkbox"/> Cerebral Palsy: Spastic Quadriplegia (343.2) | <input type="checkbox"/> Mixed receptive – expressive disorder (315.32) |
| <input type="checkbox"/> Closed Head Injury (854.0) | <input type="checkbox"/> Myelomeningocele lumbar region (741.93) |
| <input type="checkbox"/> Communication Disorder NOS (307.9) | <input type="checkbox"/> Obsessive Compulsive Disorder (300.3) |
| <input type="checkbox"/> Coordination Disorder (781.3) | <input type="checkbox"/> Oppositional Defiant Disorder (313.81) |
| <input type="checkbox"/> Developmental Coordination Disorder (315.4) | <input type="checkbox"/> Other Specified Delays in Development (315.8) |
| <input type="checkbox"/> Developmental Disorder (315.9) | <input type="checkbox"/> Pervasive Developmental Disorder NOS (299.80) |
| <input type="checkbox"/> Down's Syndrome (758.0) | <input type="checkbox"/> Tic Disorder NOS (307.20) |
| <input type="checkbox"/> Expressive Language Disorder (315.31) | <input type="checkbox"/> OTHER (name & ICD code) _____ |

CONTRAINDICATIONS/ PRECAUTIONS

Physical Therapy is prescribed for evaluation and 26 treatment sessions for the following (please check all that apply):

- Activities of Daily Living(compensatory strategies/environmental modification/adaptation/life-management skills)
- Cognitive Activities
- Fine Motor Coordination
- Gross Motor Coordination
- Neurodevelopmental Facilitation
- Neuromuscular Reeducation
- Perceptual Activities
- Sensory Integration Activities
- Therapeutic Activities/ Therapeutic Exercise/ Therapeutic Procedures
- Visual Motor Training

Physician's Signature _____ **Date** _____

Physician's Printed Name _____ **UPIN** _____

Address: _____

Street

City

State

Zip

Phone: _____ **e-mail:** _____ **Fax:** _____

