Washtenaw ISD
A REGIONAL EDUCATIONAL SERVICE AGENCY

Physical Therapy Prescription

Physical Therapy School Based Services are available to your patient based upon the recommendations of his or her IEP/IFSP planning committee. **Kindly review and complete this medical prescription and return it at your earliest convenience to:**

Physical Therapist:____
Address: ____
Phone: ____
E-mail: ____
Fax: ____

STUDENT NAME:______________________________________DOB:____________________

ATTENDING SCHOOL DISTRICT:____

DIAGNOSIS:____

PT Services includes programming in the following areas to facilitate the acquisition of functional skills:

- ☐ Evaluation
- ☐ Mobility
- ☐ Weight-bearing
- ☐ Sensory-motor
- ☐ Positioning and/or range of motion
- ☐ Assistive Technology Device(s)
- ☐ Gross motor/functional activities
- ☐ Strengthening
- ☐ Balance, posture and/or coordination
- ☐ Equipment design and/or modification
- ☐ Other: ________________________

Contraindications and/or precautions:____

As appropriate, instruction will be given to educational staff and/or family.

TO BE FILLED OUT BY THE PHYSICIAN'S OFFICE

This prescription covers school based therapy for one year from date of physician's signature.

NOTE: To participate in Physical Therapy School Based Services, a valid prescription MUST be signed by a physician and include the date the prescription was signed by the physician, physician's name, address, and NPI number. *Stamped signatures and prescriptions signed by a nurse practitioner or physician assistant are invalid for school based services.*

Physician's Signature:______________________________________ Date Signed: ____________
Print Physician's First and Last Name: ____
Physician NPI #:____
Address: ____