Summit Pediatric Therapies
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www.ptsummit.com

Patient Name: _____ DOB: _____ Phone: _____

Diagnosis: _____

ICD-9 Code: _____

Evaluate and Treat as Indicated: _____PT _____OT _____ST

Special Instructions: _____

_____

_____

TYPE OF TREATMENT

- ☐ Activities of Daily Living
- ☐ Aquatic Therapy
- ☐ Fine Motor
- ☐ Gross Motor
- ☐ Pelvic Voiding Dysfunction
- ☐ Sensory Processing
- ☐ Orthotics/Follow Up
- ☐ Oral Motor/Feeding
- ☐ Articulation
- ☐ Language

Physician Signature: _____ Date: _____

Physician's Name (printed): _____

Address: _____

_____

Phone: _____ Fax: _____