



Meeting Street

believing in the possibilities

Therapeutic Prescription

Date: _____

Student's Name: _____ **D.O.B.** _____

Referral for school-based physical therapy services for the school year.

Present therapy program:

_____ Range of Motion/Positioning

_____ Strengthening

_____ Balance/Postural Control

_____ Balance Transfer

_____ Mobility Training

_____ Family Education

_____ Indirect Services

_____ Classroom/Team Consultation

This section to be completed by Physician:

Diagnosis:

Future goals:

Physician's Orders for therapy (if different from above):

Requested addition to program:

Physician's Signature

Date