



Summit Pediatric Therapies

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Patient Name: _____ DOB: _____ Phone: _____

Diagnosis: _____

ICD-9 Code: _____

Evaluate and Treat as Indicated: _____ PT _____ OT _____ ST

Special Instructions: _____

TYPE OF TREATMENT

- | | | | | |
|---|--|---|---------------------------------------|-----------------------------------|
| <input type="checkbox"/> Activities of Daily Living | <input type="checkbox"/> Aquatic Therapy | <input type="checkbox"/> Fine Motor | <input type="checkbox"/> Gross Motor | |
| <input type="checkbox"/> Sensory Processing | <input type="checkbox"/> Orthotics/Follow Up | <input type="checkbox"/> Oral Motor/Feeding | <input type="checkbox"/> Articulation | <input type="checkbox"/> Language |

Physician Signature: _____ Date: _____

Physician's Name (printed): _____

Address: _____

Phone: _____ Fax: _____