Clinic Physician Request Form

TOTS Theracare Outpatient Therapy Services

Patient Name: _____ Date of Birth: _____ Date: _____

Physician: _____ Physician Fax: _____

Physical Therapy:

____ Eval and treat as indicated

____ Gross Motor

____ Bilateral Coordination

____ Balance Training

____ Muscle Strengthening

____ Pre-ambulation skills

____ Other: _____

Occupational Therapy:

____ Eval and treat as indicated

____ Bilateral Coordination

____ Perceptual/Motor Skills

____ Sensory Integration

____ Fine Motor

____ Muscle Strengthening

____ Feeding

____ Other: _____

Speech Therapy:

____ Eval and treat as indicated

____ Articulation

____ Language skills

____ Feeding/Oral Motor skills

____ Social Skills

____ Other: _____

Reason for request:

Therapist Signature: _____ Date: _____

Physician Signature: _____ Date: _____

_____ Approved _____ Denied