PHYSICIAN'S DIRECTION FOR PHYSICAL THERAPY

School Year: 2020-2021

Student _____ Date of Birth: _____

Dear Physician:

The Individual Education Program of the above named student requires that physical therapy services be provided in school. Please indicate any precautions/contraindications to any of the below activities.

	Precaution / Contraindications
• Standing Frame	_____
• UE Weight Bearing	_____
• LE Weight Bearing	_____
• Transfer Training	_____
• Gait Training	_____
• Therapeutic Exercises	_____
• Balance Training	_____
• Tricycle/Adaptive Tricycle	_____
• Use of Hoyer Lift	_____
• Vestibular/Sensory Tx	_____
• Other: _____	_____
_____	_____

Physician's Signature: _____ Date: _____

Physician's Name: _____
Street Address: _____
City, State, Zip Code: _____
Telephone #: _____ Fax #: _____

PHYSICIAN'S STAMP:

Thank you for your assistance.

Revised 6/20/19