



1790 E. Packard Hwy.  
Charlotte, Michigan 48813  
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Office of Special Education Services/Administrative Services

Physician: \_\_\_\_\_  
Practice Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**2011-2012 SCHOOL YEAR OCCUPATIONAL THERAPY PHYSICIAN AUTHORIZATION**

An Occupational Therapy Evaluation was completed on this student, and the following services are recommended. If you agree that this child may receive occupational therapy services, please sign below and return to Eaton Intermediate School District.

Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

District: \_\_\_\_\_ Parent(s): \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_

**SUGGESTED THERAPY PROGRAM**

- |   |  |
|---|--|
| <input type="checkbox"/> Adaptive Devices/Equipment | <input type="checkbox"/> Muscle Tone Normalization Techniques        |
| <input type="checkbox"/> Activities of Daily Living | <input type="checkbox"/> Strengthening/Endurance                     |
| <input type="checkbox"/> Cognitive                  | <input type="checkbox"/> Monitor/Improve Wheelchair Use and Mobility |
| <input type="checkbox"/> Consultation               | <input type="checkbox"/> Neuromuscular Development/ Postural Control |
| <input type="checkbox"/> Sensory Motor              | <input type="checkbox"/> Orthotic/Prosthetic Training                |
| <input type="checkbox"/> Visual Motor               | <input type="checkbox"/> Fine Motor                                  |
| <input type="checkbox"/> Visual Perceptual          | <input type="checkbox"/> Establish Maintenance Program               |
| <input type="checkbox"/> Other _____                |  |

THERAPIST NAME: \_\_\_\_\_ EXT: \_\_\_\_\_

FREQUENCY OF TREATMENT: \_\_\_\_\_

**PHYSICIAN'S COMMENTS:** \_\_\_\_\_

**PHYSICIAN'S SIGNATURE:** \_\_\_\_\_ **EFFECTIVE DATE:** \_\_\_\_\_

Physician's NPI number: \_\_\_\_\_ Are you an enrolled Medicaid provider?  Yes  No