



**DISTRICT SCHOOL BOARD OF PASCO COUNTY  
EXCEPTIONAL STUDENT EDUCATION SERVICES  
OCCUPATIONAL/ PHYSICAL THERAPY PRESCRIPTION**

MIS Form #732  
Rev. 7/13

Requested for the provision of occupational therapy services. Required prior to the initiation of physical therapy services.

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Student \_\_\_\_\_ Student # \_\_\_\_\_ DOB \_\_\_\_\_ Grade \_\_\_\_\_  
Home Address \_\_\_\_\_ School \_\_\_\_\_  
\_\_\_\_\_ Home Phone \_\_\_\_\_

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Diagnosis \_\_\_\_\_

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Precautions \_\_\_\_\_

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**Occupational Therapy Services** Check the appropriate areas below:

- |  |   |
|--|---|
| <input type="checkbox"/> Occupational Therapy Evaluation | <input type="checkbox"/> Upper Extremity Motor Skills |
| <input type="checkbox"/> Occupational Therapy Treatment  | <input type="checkbox"/> Perceptual Motor Skills      |
| <input type="checkbox"/> Developmental Program           | <input type="checkbox"/> Sensory Integration Program  |
| <input type="checkbox"/> Feeding Techniques              | <input type="checkbox"/> Home Program                 |
| <input type="checkbox"/> Functional Living Skills        | <input type="checkbox"/> Other: _____                 |

**Physical Therapy Services** At least one of the below must be checked:

- |  |  |
|--|--|
| <input type="checkbox"/> Physical Therapy Evaluation         | <input type="checkbox"/> Range of Motion Exercises     |
| <input type="checkbox"/> Physical Therapy Treatment          | <input type="checkbox"/> Upper Extremity Strengthening |
| <input type="checkbox"/> Developmental Program               | <input type="checkbox"/> Lower Extremity Strengthening |
| <input type="checkbox"/> Gait Training                       | <input type="checkbox"/> Posture Training              |
| <input type="checkbox"/> Functional Living Skills            | <input type="checkbox"/> Home Program                  |
| <input type="checkbox"/> Balance and Coordination Activities | <input type="checkbox"/> Other: _____                  |

\_\_\_\_\_  
Type or Print Physician's Name

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Address

\_\_\_\_\_  
City/State/Zip Code

\_\_\_\_\_  
Phone Number

Please return completed form to: District School Board of Pasco County  
Office for Student Support Programs and Services  
Occupational/Physical Therapist  
7227 Land O' Lakes Boulevard  
Land O' Lakes, Florida 34638

DISTRIBUTION: Cumulative Folder, Program File, School Therapy File