



Therapy Services Release

Client: _____

Parent: _____

Birthdate: _____

Address: _____

Phone: _____

City/Zip: _____

Parent/Guardian:

In order to allow your child to receive therapy and to facilitate communication, your written consent is required. Please fill in the following information in the blanks below.

1. Indicate your child's primary treating physician and the name of the associated medical practice/clinic.
2. Indicate any additional physicians and/or agencies (i.e. therapists, schools) to be included in your child's treatment planning.
3. Date and sign form to authorize consent for Carrie Kranz, OTR/L and Christine Smith, M.S., CCC-SLP/L to conduct therapy services for my child, as well as to release and obtain referrals, records, reports and verbal information that is relevant to my child's therapy program to/from:

Primary Treating Physician: _____

Medical Practice/Clinic: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Fax: _____

Other Physicians/Agencies: Kids Connection, Inc. Teachers & Staff

This release is effective for one year from the date signed. Consent may be revoked at any time, provided such revocation is in writing and signed by the person who gave the consent, and witnessed.

Date

Parent/Guardian Signature

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PHYSICIAN'S ORDER FOR OCCUPATIONAL THERAPY SERVICES

Client: _____

Parent: _____

Birthdate: _____

Address: _____

Phone: _____

City/Zip: _____

Your patient is requesting to participate in:

_____ Connections Class - specialized preschool class that incorporates occupational therapy consultation and services

_____ Motor Group - enrichment class that incorporates occupational therapy consultation and services to work on body awareness, strength, and coordination. Appropriate for **ALL** children to improve academic performance.

A physician's order is required to receive therapy services. Thank-you for supporting your patient's development. This order will be valid one year from the physician signature date.

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PHYSICIAN: Please complete the items below if applicable:

Medical Diagnosis and/or Description of Disability: _____

Current Medication: _____

Precautions or Contraindications: _____

Adaptive Equipment (e.g. splints, braces, assistive devices): _____

Additional Comments: _____

Date

Physician's Signature