



Pediatric Rehabilitation

1783 Meriden Waterbury Road, P.O. Box 786, Milldale, CT 06467
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MEDICAL CLEARANCE/PRESCRIPTION FORM

Patient's name: _____ Date of Birth: _____

Diagnosis (related to therapy): _____ ICD9 Code _____
 Other Diagnosis (es): _____ ICD9 Code(s) _____

Physician name: _____
 Physician address: _____

 Physician phone number: _____

Place physician stamp here

Does the child have:

Scoliosis	YES	NO
If scoliosis is present is it Functional or structural _____		
Degree of curvature _____		
Hip subluxation	YES	NO
If hip subluxation is present, please write degree for:		
Right _____ Left _____		
Bone conditions/History of fractures	YES	NO
Is a bone density test needed prior to intensive therapy?	YES	NO
Does the child have a shunt	YES	NO
Seizures	YES	NO
Respiratory Conditions	YES	NO
Cardiac conditions	YES	NO
Diabetes	YES	NO
High blood pressure	YES	NO
Kidney Problems	YES	NO

List any concerns regarding hip, spine, bone density issues, or other contraindications for suit therapy, or any concerns for patient to participate in a physical therapy program 5 times a week, 3 hours a day for 3 hours of therapy a day.

Current Medications: _____

PHYSICIAN ORDERS:

Evaluation and treatment for: _____ Physical Therapy _____ times a week for _____ weeks.

 Physician's signature
Provider ID # _____

 Date