HULSEY THERAPY SERVICES
Rehab & Sports Medicine
www.HulseyTherapy.com

2544 Mangum St. Commerce, TX
Phone : (903) 886-7669
Fax : (903) 886-7679

4101 Wesley, Suite H. Greenville, TX
Phone : (903) 454-8100
Fax : (903) 454-1180

# PEDIATRIC PLAN OF CARE

Patient's Name : ______________________________ Phone Number : ______________

Medical Diagnosis : ______________________ Date of Onset : ________ Date of Surgery : ________

Therapy Diagnosis : ______________________________________________

Treatment Prescribed : Evaluate and Treat as indicated    Splint / Orthotic Fit or Fabrication ________

- Continue established program
- Patient / Family Education
- Orthotic / Splint Training / Ed
- Adaptive Equipment Training
- Neurodevelopmental Treatment
- Soft Tissue Stretching
- Developmental / Motor skills
- Home Exercise Program
- Aquatic Rehab (Heated Pool)
- General Reconditioning
- Equipment Training
- Other as indicated : ______________________
- Neuromuscular Reconditioning Program
- Cognitive / Perceptual Training
- Sensory Integration Training
- Oral Motor / Feeding Activities
- Gait Training / Pre-Gait preparedness

Frequency : *TIW* *BIW* *PRN* *Other*________ Duration : ______ Recheck by Physician : ______ PRN

Special Instructions or Precautions : ______________________________________

## MEDICAL SUMMARY

Related Medical Findings : ______________________ Medications : See attachment in chart

Summary of Previous Treatment related to this Diagnosis : ______________________

### Goals for Rehab : *Short Term* *To be met in ______ wks*

**Fine Motor Skills**

- Reach and grasp ____________________
- Stack ________Blocks in __________
- String _____Beads together in _______
- Complete ______ piece puzzle
- Use hands to ______________________
- Finger feed _______________________
- Hold a crayon _____________________
- Catch a Ball _______________________
- Use pencil to ______________________
- Copy _____ shapes _________________

**Gross Motor Skills**

- Roll over _________________________
- Sit alone __________________________
- Crawl on hands and knees _________
- Play in half-kneel _______________
- Play in tall kneel ________________
- Pull to stand ______________________
- Stand alone _______________________
- Walk ____________________________
- Kick a ball _______________________
- Jump ____________________________

**General**

- Improve muscle tone to ____________
- Tolerate activities ________________
- Tolerate ROM ____________________
- Tolerate Stretching of ____________
- Tolerate sensory activities __________
- Tolerate vestibular activities _________
- Tolerate tactile activities with hands
- Tolerate oral motor activities
- Feed self using fingers
- Feed self using spoon / fork __________

### Goals for Rehab : *Long Term* *To be met in ______ wks*

**Fine Motor Skills**

- Reach and grasp ____________________
- Stack ________Blocks in __________
- String _____Beads together in _______
- Complete ______ piece puzzle
- Use hands to ______________________
- Finger feed _______________________
- Hold a crayon _____________________
- Catch a Ball _______________________
- Use pencil to ______________________
- Copy _____ shapes _________________

**Gross Motor Skills**

- Roll over _________________________
- Sit alone __________________________
- Crawl on hands and knees _________
- Play in half-kneel _______________
- Play in tall kneel ________________
- Pull to stand ______________________
- Stand alone _______________________
- Walk ____________________________
- Kick a ball _______________________
- Jump ____________________________

**General**

- Improve muscle tone to ____________
- Tolerate activities ________________
- Tolerate ROM ____________________
- Tolerate Stretching of ____________
- Tolerate sensory activities __________
- Tolerate vestibular activities _________
- Tolerate tactile activities with hands
- Tolerate oral motor activities
- Feed self using fingers
- Feed self using spoon / fork __________

Rehab Potential: Good Fair Poor Patient aware of diagnosis & Prognosis : Yes ____ No _____

**I CERTIFY THAT THE ABOVE SERVICES ARE REQUIRED BY THIS PATIENT ON AN OUT-PATIENT BASIS.**

**Referring/Treating Professional's Signature : ______________________________ Date : ______________**

**Printed Name of Referrer : ________________________________________ Phone : _______________**

*Referrer must be authorized by the state of Texas , and by their specific licensure board to refer such services as outlined above.*