



5423 Lake Howell Road  
Winter Park, FL 32792

Phone: 407-679-STEP  
Fax: 407-679-STEP

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Medical Doctor:

Your patient \_\_\_\_\_ is interested in participating in an intensive physical and occupational therapy program. The child will engage in therapy for a total of four hours a day, five days a week for three weeks. The purpose of intensive suit therapy is to decrease pathological reflexes, normalize muscle tone and provide correct proprioceptive feedback, which will allow for improved functional movement and skill. This program utilizes a soft orthotic device to correctly align and provide resistance throughout the body called the Therasuit™. The child will perform a series of strengthening exercises along with movement activities while wearing the Therasuit™ that may generate weight bearing forces of up to 30 pounds.

This rigorous program may increase the child's blood pressure, body temperature, heart rate and respirations. It is necessary for you to fill out the Patient Medical History Form so as to make us aware of any necessary precautions that must be taken to ensure the safety of the child during therapy. Please include a copy of the child's most recent hip x-rays.

Your patient will be treated by skilled physical and occupational therapists. Please write a prescription for:

**PT/OT 5 times a week for 3 weeks. Evaluate and Treat.  
Include the child's diagnosis and diagnosis code on the prescription.**

Thank you for your time and efforts. If you have any additional questions, you may contact us at 407-679-7837.

Sincerely,

Innovative Children's Therapy, Inc.



*Making Strides... One Step at a Time*

www.innovativechildrenstherapy.com

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### Patient Medical History

Patient: \_\_\_\_\_ DOB: \_\_\_\_\_

Diagnoses: \_\_\_\_\_

Physician: \_\_\_\_\_ Physician's Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Physician's Fax: \_\_\_\_\_

\_\_\_\_\_

Please indicate if the patient has a history of any of the following:

Cardiac conditions: YES NO \_\_\_\_\_

High blood pressure: YES NO \_\_\_\_\_

Shunt: YES NO \_\_\_\_\_

Bone conditions: YES NO \_\_\_\_\_

Would you recommend bone density testing prior to participating in intensive therapy? YES NO

Fractures: YES NO \_\_\_\_\_

Hip Subluxation: YES NO \_\_\_\_\_

Degree of subluxation: Right \_\_\_\_\_ Left \_\_\_\_\_

Please provide most recent hip x-ray and report

Scoliosis: YES NO Degree of curvature \_\_\_\_\_

Seizures: YES NO \_\_\_\_\_

Are the seizures controlled by medicine? YES NO \_\_\_\_\_

Date of last seizure: \_\_\_\_\_

Respiratory condition: YES NO \_\_\_\_\_

Diabetes: YES NO \_\_\_\_\_

Kidney condition: YES NO \_\_\_\_\_

Please list any other conditions that would require special precautions or that would deem intensive therapy contraindicated.

\_\_\_\_\_  
\_\_\_\_\_

Do you recommend that this patient participate in an intensive physical and occupational therapy program? YES NO \_\_\_\_\_

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

Date \_\_\_\_\_