St. Lucie Public Schools
Documentation of Physical Therapy Services
Provider # 1669547451

Month of: _____

Student Name _____ **Diagnosis Code** _____ **School #** _____ **IEP Date** _____
Student ID # _____ **Medicaid #** _____
DOB _____
Minutes Per Week _____

	Place of Service	Therapy Method	Progress
Date: _____ Length of Time (Minutes) _____ ☐ 97001 Evaluation by Therapist ☐ 97110 Individual Session with Therapist ☐ 97110HM Individual Session with Assistant ☐ 97150 Group Session with Therapist #_____ ☐ 97150HM Group Session with Assistant #_____ ☐ 97001TG Wheelchair Evaluation/Fitting	(Circle) School Home	GT. T/MOB REL/FAC STR/ROM G.M. BAL/COORD W/C TR/TRANSIT MON. CLASS PT POSIT/L TR CONS PAR CONT MD CONT W/C A/M EVAL/ASSES D/C/MON A.D.	☐ Mastered ☐ Progress ☐ Regression ☐ Other: Signature Credentials Date
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Therapist Name:
(Please Print) _____

White: Medicaid Office Canary: OT/PT Dept.