The School Board of St. Lucie County, Florida
Exceptional Student Education
772-429-4570

Occupational Therapy Plan of Treatment

Student Name:		
School: #:	DX:	
Student ID#:	DX Code:	
Medicaid #:	ESE Program:	
DOB:	Physician:	
Grade:	Teacher:	
IEP Date:	Reeval Date:	
Therapist Name:		
Signature: Name/Credentials		Date:

Special Therapy Methods to be Provided

FM: Fine Motor Activities	**SM**: Sensory Motor Activities
R/F: Relaxation/Facilitation	**OM**: Oral Motor
HW: Handwriting	**V/P:** Visual/Perceptual Activities
VS: Vocational Skills	**SC:** Self-Care
TCD: Treatment Coordination	**TC**: Teacher Consultation
PC: Parent Contact	**MDC**: Physician Contact
LS: Leisure Skills	**MCT**: Monitor Classroom Therapy
TSP: Training of School Personnel	**ROM/Str**: Range of Motion/Strengthening
PCG: Training of Primary Care Giver	**Ad/AsstD**: Adaptive/Assistive Devices
LFS: Life Skills: attending, organizational, initiation, follow through	

Medical Alert:

_____________________________________ qualifies for educationally relevant Occupational Therapy services. Services may be provided by an OTR/L and/or a COTA/L and include direct/indirect and/or group therapy. Recommend ____________________ minutes per week _______________times per week for the duration of the current IEP. ESY ______________ minutes per week ____________ times per week.

Description of Student's Present Level of Functioning:

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List if Student has Behavior Plan or Accommodations:

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Long Term Goals:

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Short Term Goals:

	Date Mastered