Swing for the Stars
PEDIATRIC THERAPY CENTER, LLC

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Physical Therapy Doctor's Order

Child's Name: _____ **Parent's Name:** _____
Date of Birth: _____ **Phone Number:** _____

Services Requested:

☐ Physical Therapy Evaluation ☐ Physical Therapy Treatment

Diagnosis (ICD 10):

☐ F84.0- Autistic Disorder
☐ F84.5- Asperger's Syndrome
☐ F84.8- Other Pervasive Developmental Disorder
☐ Q90.9- Downs Syndrome
☐ Q99.2- Fragile X Chromosome

☐ F90.0- ADHD, inattentive type
☐ F90.1- ADHD, hyperactive type
☐ F90.2- ADHD, combined type
☐ M43.6- Torticollis

☐ G80.0- Spastic quadriplegic- CP
☐ G80.2- Spastic hemiplegic CP
☐ G80.4- Ataxic CP

☐ G80.1- Spastic diplegic CP
☐ G80.3- Athetoid CP
☐ G80.8- Other CP

☐ G81.01- Flaccid hemiplegia affecting right dominant side
☐ G81.03 Flaccid hemiplegia affecting right non-dominant side

☐ G81.02- Flaccid hemiplegia affecting left dominant side
☐ G81.04- Flaccid hemiplegia affecting left non-dominant side

☐ F82- Specific dev disorder of motor function
☐ M24.20- Disorder of ligament, unspecified site*
☐ G96.9- Disorder of central nerv. system, unspecified*
☐ M35.7- Hypermobility syndrome
☐ R26.0- Ataxic gate
☐ R26.2- Difficulty walking, not elsewhere classified
☐ R62.59- Other lack of expected normal physiological development in childhood

☐ M62.81- Muscle weakness (generalized)
☐ M79.60- Pain in limb (unspecified)*
☐ R26.1- Paralytic gate
☐ R26.81- Unsteadiness on feet
☐ R62.0- Delayed milestones in childhood
☐ R27.8- Other lack of coordination
☐ Unspecified site of sprain/strain
Affected area: _____

☐ Other: _____

I do hereby determine the services listed above to be medically necessary

Physician's Signature: _____ Date: _____

Physician's Name Print: _____ NPI Number: _____

Address: _____ Phone Number: _____