Pediatric Therapy POC

_____PT _____OT _____ST

Name______________________________________DOB:_________________Dx___________________________Initial Eval date:______________

		Baseline/Current Status Certification Periods (start-end dates)							Date Goal Met/ Discharged
GOALS ↓	***Tx freq/duration: →***								
	Therapist's Initials: →								

Therapist's Signature____