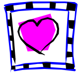 INITIAL TREATMENT – CONSULTATION SCHEDULE REQUEST

Child's Name: ______________________________ Date: __________

Dear Parent,
In the event your child requires therapy we request that you complete this information to help us schedule your child and to plan a time for your initial consultation and education program. Please note that we try to schedule children under 5 years of age before 2:00 and older children after school.

Treatment for: Speech-Language
Occupational Therapy
Physical Therapy

Please cross out the times in which you WOULD NOT be able to attend therapy.

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
7:00	7:00	7:00	7:00	7:00	7:00
8:00	8:00	8:00	8:00	8:00	8:00
9:00	9:00	9:00	9:00	9:00	9:00
10:00	10:00	10:00	10:00	10:00	10:00
11:00	11:00	11:00	11:00	11:00	11:00
12:00	12:00	12:00	12:00	12:00	12:00
1:00	1:00	1:00	1:00	1:00	1:00
2:00	2:00	2:00	2:00	2:00	2:00
3:00	3:00	3:00	3:00	3:00	3:00
4:00	4:00	4:00	4:00	4:00	4:00
5:00	5:00	5:00	5:00	5:00	5:00

Before therapy begins we would like to schedule a consultation to discuss your child's evaluation test reports and recommendations. We also have a parent education program to help you understand your child's therapy. This program varies depending on the needs of your child. For example: sensory integration, feeding…

We would like to schedule your consultation for:

____

Day Date Time

We will schedule treatment to begin following your consultation and once we have authorization from your insurance company, if required, and/or you advise us that you are ready to begin.
Sincerely, FTH therapists