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THERAPY SCHEDULE FORM

CHILD'S NAME _____

In order, which day best fits your needs for Therapy Services: (For example if Tuesday is the best day, place a one in front of it. If Friday is second best, place a two in front of it, etc...)

____ Monday ____ Tuesday ____ Wednesday ____ Thursday ____ Friday ____ Other

Time if day preferred for your therapist's visit: _____

Will therapy be in your home? Yes ____ No ____ Comment _____

If not in your home, please give the name, address, and phone number where the therapy will be held:

Name of Day Care or Other: _____

Street: _____

City: _____

State: _____

Phone Number: _____

Best time of day to reach you: _____

Day time phone number to reach you: _____

May we leave a message on your voice mail? Yes _____ No _____

Other considerations: _____

Parent /Guardian Name: _____

Parent /Guardian Signature: _____