GREAT LAKES ORTHOPEDIC LABS, INC.
1031 Main Street, Buffalo, NY 14203 / Tel. (716) 893-4116

THERAPEUTIC INTERVENTION AND/OR REPOSITIONING/HOME PROGRAM

Patient's name: ____

Parent Documentation: I have been instructed by my pediatrician on how important a repositioning/home program of therapy is and I have been following such program since _______________________.

___ Yes ___ No I have been alternating back and side sleeping and have rearranged the crib relative to primary light source.

___ Yes ___ No I have been providing more tummy time and limiting time my Child's time spends in a supine position.

___ Yes ___ No I have been limiting my child's time spent in strollers, carriers and Swings.

___ Yes ___ No Since my child has torticollis I have been doing neck motion exercises.

List any other methods of prevention:

Has this child been referred to obtain Therapeutic Intervention by a Therapist?

_____Yes ____No

Has this child received Therapeutic Intervention by a Therapist? _____Yes ____No

If yes, how many times/week ________

If no, has anyone prescribed or suggested your child receive Physical Therapy.

___ Yes ___ No

Is this child still presently in therapy? _____Yes _____No

Dated: __________________

____
Signature of Parent/Guardian

____
Print name as signed above