

Elks Camp Grassick  
PO Box F, Dawson, ND 58428  
701-327-4251  
campgrassick@gmail.com

## Occupational and Physical Therapy Report

### OCCUPATIONAL AND PHYSICAL THERAPY REPORT

To be completed if the individual is receiving or could benefit from occupational and/or physical therapy.

Name of Applicant: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

How does this individual ambulate?

Independently     Crutches     Walker     Wheelchair

If this individual uses a wheelchair, how independent is he/she in ADLs, transfers, mobility, etc.?

Does this individual wear orthotic devices? \_\_\_\_\_

If so, what type of orthotic devices?

When do they wear their orthotics?  Full Time     Part Time     Night

### OCCUPATIONAL THERAPIST INFORMATION

Name of Individual's Occupational Therapist: \_\_\_\_\_

Occupational Therapist's Email: \_\_\_\_\_

School System or Agency of OT: \_\_\_\_\_

Address of School or Agency: \_\_\_\_\_

School or Agency Phone Number: \_\_\_\_\_

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If this individual is accepted, I would like to receive a copy of the report and follow up information after camp:  Yes  No

How would you like to receive information from camp?

I would like to receive paper copies in the mail.

I would like to receive digital copies by email.

I would like to receive paper and digital copies.

Has this individual ever been evaluated for Occupational Therapy?  Yes  No

Is this individual presently receiving Occupational Therapy services?  Yes  No

If so, how many times per week: \_\_\_\_\_ For what length of time? \_\_\_\_\_

What areas and/or concerns are being addressed in OT? Please give a brief description of therapy this individual is presently receiving.

Please indicate specific areas of concentration you would like addressed or certain skills you would like us to work on while this individual is attending camp.

Please include or attach any other information that you think would be helpful to our staff while working with this individual.

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Occupational and Physical Therapy Report

**PHYSICAL THERAPIST INFORMATION**

Name of Individual's Physical Therapist: \_\_\_\_\_

Physical Therapist's Email: \_\_\_\_\_

School System or Agency of PT: \_\_\_\_\_

Address of School or Agency: \_\_\_\_\_

School or Agency Phone Number: \_\_\_\_\_

If this individual is accepted, I would like to receive a copy of the report and follow up information after camp:  Yes  No

How would you like to receive information from camp?

I would like to receive paper copies in the mail.

I would like to receive digital copies by email.

I would like to receive paper and digital copies.

Has this individual ever been evaluated for Physical Therapy?  Yes  No

Is this individual presently receiving Physical Therapy services?  Yes  No

If so, how many times per week: \_\_\_\_\_ For what length of time? \_\_\_\_\_

What areas and/or concerns are being addressed in PT? Please give a brief description of therapy this individual is presently receiving.

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