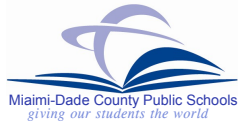


**DIRECT CONSULT  
(OCCUPATIONAL/PHYSICAL THERAPY PROGRAMS)**



PRINT STUDENT'S NAME	(LAST)	(FIRST)	(M.I.)
_____			

DATE (MM/DD/YY)	_____
STUDENT ID. NO.	_____

PLAN FOR CONSULTATIVE OT/PT	COMMENTS	DATE	INITIALS
Purpose:			
Activities:			
Implementation:			
Evaluative Criteria:			