Developmental & Rehabilitation Services
Constraint Induced Therapy
Application

Date

Child's Name: Social Security #:

Address

City: State: Zip: Phone: - -

Gender: ☐ Male ☐ Female Date of birth:

Caregiver's name: Relation to patient:

E-mail: Social Security #:

Primary language: Interpreter needed: ☐ Yes ☐ No

Additional contact person: Phone:

Insurance Information

Primary Insurance Provider: Phone: - -

Contract #:

Policyholder:

Date of birth:

Social Security #:

Secondary Insurance Provider:

Contract #:

Secondary Insurance Provider: Phone: - -

Contract #:

Policyholder:

Date of birth: Social Security #:

Primary care physician and referring, if applicable:

Therapy currently receiving: ☐ OT ☐ PT ☐ SLP Where?

OFFICE USE ONLY

Scheduled dates:_____

Insurance coverage for OT:_____

Authorization # and visits:_____

Patient ID

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Diagnosis

☐ In-utero Stroke/ Stroke around birth

☐ Cerebral palsy

☐ Traumatic Brain Injury

☐ Brachial Plexus Injury ☐ From birth ☐ Acquired

☐ Other:

Side of body affected: ☐ Right ☐ Left ☐ Both

Affected Arm and Hand Information

1 . How much does the child spontaneously use his /her most affected hand/arm?

☐ Under 25% of time ☐ 25% - 50% of time ☐ over 50% of time

2 . Can the child open his/her hand? ☐ Yes ☐ No If yes, how much?

3 . Can the child move his/her thumb away from the palm? ☐ Yes ☐ No

4 . Can the child straighten his/her elbow? ☐ Yes ☐ No

5 . Can the child raise his/her arm toward the head? ☐ Yes ☐ No If yes, how much?

6 . Can the child pick up a small toy/object? ☐ Yes ☐ No

7 . Can the child release a small toy/object if place in the hand or picked up by him/her? ☐ Yes ☐ No

Medication Information (List all current medications and reason prescribed)

Other Health Information

Seizures	☐ Yes	☐ No	Allergies	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Developmental Delay	☐ Yes	☐ No
Cognitive Impairment	☐ Yes	☐ No	If Yes, Comment		

Return completed form and most recent therapy reports (OT, PT, ST) to:

Constraint Induced Therapy
All Children's Hospital
Box 6500001201
880 6th Street South
St. Petersburg, Fl 33701

Or fax to: (727) 767-8847