



**Very Special Kids**  
**Physiotherapy Management Plan**

GOLDCARE NUMBER ( CLIENT ID)	
GIVEN NAME	
FAMILY NAME	
DATE OF BIRTH	SEX

*Instructions – Use a new form if Physiotherapy Management has changed from previous visit or child has not stayed at VSK in the last 12 month period. Tick boxes where applicable and describe in comments space provided.*

**Musculoskeletal Care**

<b>Positioning requirements</b>	

Equipment Used	Tick	Supervision required ( Select one)				Length of Time
Tumbleform	<input type="checkbox"/>	Constant <input type="checkbox"/>	Close <input type="checkbox"/>	Minimal <input type="checkbox"/>	_____	
Scooped wedge	<input type="checkbox"/>	Constant <input type="checkbox"/>	Close <input type="checkbox"/>	Minimal <input type="checkbox"/>	_____	
Mat on floor	<input type="checkbox"/>	Constant <input type="checkbox"/>	Close <input type="checkbox"/>	Minimal <input type="checkbox"/>	_____	
Other	<input type="checkbox"/>	Constant <input type="checkbox"/>	Close <input type="checkbox"/>	Minimal <input type="checkbox"/>	_____	

<b>Limb Stretches</b>	
(please give details)	

<b>Splints</b>	Length of time worn daily :	hours	mins
<b>Braces</b>	Length of time worn daily :	hours	mins
<b>Ankle Foot Orthosis (AFO)</b>	Length of time worn daily :	hours	mins

<b>Activities to practice</b>	Rolling <input type="checkbox"/>	Head control <input type="checkbox"/>	Reaching <input type="checkbox"/>	Sitting balance <input type="checkbox"/>
	Walking <input type="checkbox"/>			
	Other			

**Reviewed by family and signed**

Date	Signature	Date	Signature

**Reviewed By Staff Member**

Date	Signature	Designation	Date	Signature	Designation

**Proceed to Page 2 for completion of Respiratory Care Physiotherapy Management (if applicable).**





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Page 2

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Respiratory Care

▶ What are your child's normal respiratory secretions like?

<b>Comment</b>	Please describe

▶ Does your child need a Nebuliser?

<b>Yes</b> <input type="checkbox"/>	Explain Contents:
<b>No</b> <input type="checkbox"/>	Quantity in millilitres:
<b>Comment:</b>	

Number of session per day:	Length of session:
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Please sign this authorisation confirming the information given is current and any necessary changes have been endorsed and dated.

Reviewed by family and signed

Date	Signature	Date	Signature

Reviewed By Staff Member

Date	Signature	Designation	Date	Signature	Designation



Form 14

Physiotherapy Management Plan