Referral for School-Based Physical/Occupational Therapy Evaluation

STUDENT: _____

TYPE OF REFERRAL: _____PHYSICAL _____OCCUPATIONAL

HAS STUDENT PREVIOUSLY RECEIVED *OT* AND/OR *PT?* _____YES _____NO

SCHOOL: _____ DATE OF BIRTH: _____

OTHER DIAGNOSIS (Seizures, Tics, Muscle Disorders, etc.): _____

PARENTS/GUARDIAN: _____

HOME ADDRESS: _____

PHONE HOME: _____ WORK: _____ CELL: _____

DOCTOR'S NAME: _____

FINE MOTOR AND/OR SENSORY CHECKLIST ATTACHED? _____ YES _____ NO

REASON FOR REFERRAL: _____

_____

_____

OTHER INFORMATION: _____

FOR COMPREHENSIVE REEVALUATIONS:

TYPE OF PROGRAM: _____Inclusion _____Behavior Mod _____Life Skills _____Study Skills

SPED ELIGIBILITY (list subcategories): _____

RELATED SERVICES: _____

LSC OR REFERRING SPED TEACHER: _____

DATE: _____