

214A

Re: _____ (Student's Name)

DOB: _____

To the Physician:

The student named above currently attends _____.

This Student has been recommended for Occupational Therapy/ Physical Therapy. A Doctor's referral is necessary for the service to be administered. Frequency and Duration of services will be determined by the IEP Team at the school. Please fill out and sign the referral form below and return it to _____, so that services may be provided for this child during school hours.

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REFERRAL FOR OCCUPATIONAL THERAPY/ PHYSICAL THERAPY

STUDENT'S NAME:

ADDRESS:

DIAGNOSIS:

DISABILITY:

PERTINENT MEDICAL INFORMATION:

PRECAUTIONS:

RELATED SERVICE RECOMMENDATIONS: OT _____ PT _____

Physician's Signature _____ Date: _____