REGION III SPECIAL EDUCATION

1800 STOREY LANE, COTTAGE HILLS, IL. 62018
PHONE: 618-462-1031 FAX: 618-462-1035

OCCUPATIONAL/PHYSICAL THERAPY REFERRAL FORM

____INITIAL ____REEVALUATION OT eval____ PT eval____

Therapy Evaluation can be requested for a child who is already eligible for special education services or as a part of a case study to determine she/he is eligible.

STUDENT NAME:_____ M/F_____ DOB:_____

PARENT/GUARDIAN:_____PHONE: (Home)_____
(Work)_____

HOME ADDRESS:_____CITY:_____ZIP:_____

DISTRICT:_____SCHOOL:_____GRADE:_____

TEACHER_____EARLY CHILDHOOD: A.M. _____P.M.____
Email_____
CURRENT SPECIAL EDUCATION PLACEMENT ELGIBILITY OR IS THIS THE INITIAL CASE STUDY?_____

_____

_____

REASONS FOR REFERRAL: _____

_____

D**oes child have any apparent medical problems or known medical diagnosis i.e., on medication, seizures, wear glasses, hearing loss, chronic illness, etc.?_____**

_____

_____

PHYSICIAN'S NAME_____PHONE:_____

ADDRESS:_____CITY:_____ZIP: _____

CASE STUDY DUE DATE: _____

IN WHAT EDUCATIONAL AREAS IS THE STUDENT'S PERFORMANCE THE MOST CONCERN TO YOU?

_____

_____

_____

_____

WHAT METHODS/STRATEGIES HAVE BEEN TRIED TO DEAL WITH THESE CONCERNS?

_____

_____

_____

_____

_____

ANY INFORMATION WHICH YOU WOULD LIKE TO ADD/EDUCATIONAL CONCERNS OR INTERVENTIONS UTILIZED FOR:_____

_____

_____

_____

REFERRING PERSON_____POSITION_____

_____

SPECIAL EDUCATION COORDINATOR SIGNATURE

Note: Packet must include: Referral Form, Therapy Checklist and Parent Consent.