

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: _____

Does 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.

