

MEDICAL REFERRAL INFORMATION

Dear Physician:

The Region 10 Education Service Center

*Last medical dated _____

has received a new request for evaluation

has provided therapy services

for _____ (Student's Name) (____ / ____ / ____) (Date of Birth) at _____ (District/SSA)

by an occupational and/or physical therapist. Evaluation and/or services specifically address the student's educational versus medical needs. Following evaluation, if Occupational and/or Physical Therapy Related Service is recommended, an individualized education program is developed collaboratively with the teacher to benefit the student's ability to function within the school, home, and community.

The therapist will be available to assist with facilitation of functional skills in the school environment:

- Fine and gross motor development
- Oral motor development
- Mobility
- Positioning
- Self-help skills
- Environmental adaptations

Please complete the requested information below:

Diagnosis _____

Recent Surgeries _____

Medical Precautions (i.e., seizures, asthma, other respiratory problems, allergies, heart condition, atlanto-axial instability, aspiration)

Explain _____

Oral feeding: ___Regular diet ___Tube feedings ___Other: List specific recommendations _____

Weightbearing contraindications _____

Check Diagnostic Workup Completed Within Past 12 Months

___GI series ___Swallow study (attach recommendations re: texture, consistencies, positioning, etc.)

___Neuromuscular Testing (EMG) ___Neurological Testing (MRI, CAT Scan, EEG) ___Orthopedic (x-ray, gait analysis, bracing)

Davies Series? ___Yes ___No Results: _____

Medications _____

Other pertinent medical information _____

SIGNATURE OF PHYSICIAN OR OTHER APPROPRIATELY CERTIFIED/LICENSED MEDICAL PROFESSIONAL INDICATES RECOMMENDATION FOR OCCUPATIONAL/PHYSICAL THERAPY RELATED SERVICE IN THE SCHOOL SETTING.

Signature _____

Date _____

Name (PLEASE PRINT) _____

UPIN # _____

Address _____

Phone _____