

OCCUPATIONAL AND/OR PHYSICAL THERAPY RELATED SERVICE REQUEST

OT/PT RELATED SERVICES ARE AVAILABLE TO SPECIAL EDUCATION STUDENTS WHO REQUIRE SUCH SERVICES TO BENEFIT FROM INSTRUCTION.

Name _____ D.O.B. _____ Age _____ Sex _____

Circle Eligibility Code (Primary & Secondary) MD OI OHI AI VI DB ED LD SI AU ID NCEC TBI

PLEASE CHECK APPROXIMATE LEVEL OF FUNCTIONING / IQ _____ 0-30 _____ 30-50 _____ 50-70 _____ Above 70

_____ () _____
District Campus Phone Principal

_____ Pupil's School Day begins _____; ends _____
Teacher (time) (time) Placement/Grade

_____ Address City
Parent's Name

_____ Home phone number
Mother's Day Time phone number Father's Day Time phone number

PLEASE COMPLETE BACK 

As stipulated in Rules and Regulations for Providing Special Education Services, informed consent and written parent permission in the language best understood by the parent have been obtained for OT/PT related service screening, evaluation, follow-up and/or OT/PT related service. In addition to parent consent, for those students 18-21 years of age or married, informed consent and written student permission in the language best understood by the student have been obtained for OT/PT related service screening, evaluation, follow-up and/or OT/PT related service. All Procedural Safeguards according to Federal Regulations and State Law have been followed. Services requested below are based upon the recommendation of the ARD Committee and are documented and justified in the student's IEP.

REQUEST FOR OCCUPATIONAL/PHYSICAL THERAPY RELATED SERVICE

SCREENING After screening results have been reviewed by the ARD, a **completed OT/PT Medical Referral, Parent Information Release Form and current IEP** will be forwarded to Region 10, if evaluation is recommended by the ARD.

EVALUATION* and ONGOING SERVICE **RE-EVALUATION*** A **completed current OT/PT Medical Referral, Parent Information Release Form, and current IEP** are attached for evaluation/ongoing service/re-evaluation.

I have asked _____ to provide educational perspective and collaborate with the therapist to develop and implement therapy activities. Complete re-evaluation by (date) _____.

TRANSFER STUDENT

ONGOING SERVICE **RE-EVALUATION*** A **completed current OT/PT Medical Referral, Parent Information Release Form, and current IEP** (including all current school and therapy goals/objectives/benchmarks) and current therapy evaluation(s) are attached.

___ Temporary ARD ___ Permanent 30 day ARD held _____
___ Amount of Service (requested at ARD) OT service: _____
PT service: _____

*If this is not an initial evaluation, the ARD/REED process indicates need for evaluation checked.

Authorizing Signature (Director of Special Education)

Date

FOR SCREENING, EVALUATION, OR TRANSFER STUDENT THIS PAGE MUST BE COMPLETED

Dear Special Educator:

Special education students referred to Region 10 for education based OT and/or PT related services should evidence difficulties impacting educational performance and/or participation as identified through some of the following questions. Please carefully observe this student and respond to all items below. This information will assist in the selection of materials and screening/assessment instruments most appropriate to this student's needs. Thank you.

YES	NO	DOES THIS STUDENT
_____	_____	Use any of the following aids? If yes, please check: ___wheelchair ___walker ___crutches ___braces ___adaptive seating/positioning equipment ___hearing aid ___glasses ___oxygen ___GI tube ___communication device ___other_____
_____	_____	Experience frequent health problems? Comment_____
_____	_____	Assume and maintain sitting without support?
_____	_____	Assume and maintain standing without support?
_____	_____	Walk independently?
_____	_____	Move independently around the school environment?
_____	_____	Have difficulty participating in the P.E. program?
_____	_____	Manipulate objects appropriate for classroom participation?
_____	_____	Perform paper/pencil tasks appropriate for classroom participation?
_____	_____	Evidence problems with chewing/swallowing?
_____	_____	Have reading skills appropriate for classroom participation?
_____	_____	Have basic math concepts appropriate for classroom participation?

What are your areas of concern? _____

What is the location and best time to observe student relative to your areas of concern? _____

Desired educational outcomes: _____

Additional comments: _____

COMPLETED BY _____ RELATIONSHIP TO STUDENT _____