

CPS, Office of Specialized Services

Occupational/Physical Therapy

Referring School: _____

School phone number: _____

School fax number: _____

Physician's Occupational and/or Physical Therapy Referral

Child's Name: _____	Date of Birth: _____
Home Address: _____	Telephone: _____
Student ID #: _____	Grade: _____
	School: _____

(To be completed by physician, a delegated physician assistant or an advanced practice nurse collaborating with a physician.)

Medical Diagnosis/History (seizures, etc): _____

Precautions & Contraindications: _____

Recent surgeries or changes in condition (please include weight bearing status): _____

Current Medications/Dosage/Frequency: _____

Wheelchair/Equipment Needs: _____

Check if current problem: vision hearing swallowing Incontinence

Is student toilet trained? YES NO

Can student negotiate stairs: YES NO Comments:

Regular physical education: YES NO **If no**, modified physical education: YES NO

(To be completed by physician, a delegated physician assistant or an advanced practice nurse collaborating with a physician.)

Physical Therapy Recommendations

Evaluate and Treat as appropriate for **school-based goals**.

Comments:

Physician's Signature: _____

Date: _____

Physician's Name: _____
(print)

Phone: _____

Address:

Hospital Affiliation:

(To be completed by physician, a delegated physician assistant or an advanced practice nurse collaborating with a physician.)

Occupational Therapy Recommendations

Evaluate and Treat as appropriate for **school-based goals**.

Comments:

Physician's Signature: _____

Date: _____

Physician's Name: _____
(print)

Phone: _____

Address:

Hospital Affiliation: