CLINICAL SERVICES REFERRAL FORM (OT/PT/AT)

Clinical Services

DATE: _____ **REFERRED BY:** _____

SCHOOL SYSTEM: _____

STUDENT: _____ **DATE OF BIRTH:** _____

SCHOOL: _____ **GRADE/CLASSROOM:** _____

SCHOOL CONTACT/TEACHER: _____

CONTACT PHONE: _____ **EMAIL:** _____

PARENT(S)/GUARDIAN(S): _____

HOME ADDRESS: _____

PARENT PHONE: _____ **EMAIL:** _____

PRECAUTIONS/ALLERGIES: _____

MEDICATIONS/EQUIPMENT: _____

☐ ***Authorization for Exchange of Information*** included and complete with at least Physician indicated and signed by parent/guardian

Please check ☒ SERVICE/THERAPY as well as Evaluation/Assessment and/or Services per IEP/504 Plan:

☐ **ASSISTIVE TECHNOLOGY (AT):**

☐ **Evaluation/Assessment:**

- ☐ *Consent to Conduct an Initial Evaluation/Reevaluation* or *504 Plan Consent* with parent/guardian signature
- ☐ *AT Screener*

☐ **Services to Continue as Indicated on IEP *(Please indicate PPT/504 date and service/frequency)***

Comments: _____

☐ **OCCUPATIONAL THERAPY (OT):**

☐ **Evaluation/Assessment:**

- ☐ *Consent to Conduct an Initial Evaluation/Reevaluation* or *504 Plan Consent* with parent/guardian signature
- ☐ *OT Assessment Criteria Sheets*
- ☐ Student Samples

☐ **Services to Continue as Indicated on IEP *(Please indicate PPT/504 date and service/frequency)***

Comments: _____

☐ **PHYSICAL THERAPY (PT):**

☐ **Evaluation/Assessment:**

- ☐ *Consent to Conduct an Initial Evaluation/Reevaluation* or *504 Plan Consent* with parent/guardian signature
- ☐ *PT Assessment Criteria Sheets*

☐ **Services to Continue as Indicated on IEP *(Please indicate PPT/504 date and service/frequency)***

Comments: _____

DIRECTOR/SUPERVISOR/DESIGNEE: **DATE:**

FOR ACES CLINICAL SERVICES USE ONLY:

DISCHARGE: **Date:** _____ **Reason:** _____

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