



Referring School _____
School phone number _____
School fax number _____

Physicians Referral for Occupational and/or Physical Therapy

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

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

Medical Diagnosis/History (seizures, etc): _____	ICD-10 Code _____
Precautions & Contraindications: _____	
Recent surgeries or changes in condition (please include weight-bearing status): _____	
Current Mediations/Dosage/Frequency: _____	
Wheelchair/Equipment Needs: _____	
Check if current problem <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Swallowing <input type="checkbox"/> Incontinence	
Is student toilet trained? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Can the student negotiate stairs: <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments: _____
Regular physical education: <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, modified physical education: <input type="checkbox"/> Yes <input type="checkbox"/> No

COMPLETE ONLY RELEVANT SECTION(S)

(To be completed by a 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: _____	National Provider Identifier (NPI)

	Medicare Provider Number
Physician's Signature: _____	Date: _____
Physician's Name: _____	Phone: _____
	:
Address: _____	
Hospital Affiliation _____	

(To be completed by a 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: _____	National Provider Identifier (NPI)

	Medicare Provider Number
Physician's Signature: _____	Date: _____
Physician's Name: _____	Phone: _____
Address: _____	
Hospital Affiliation _____	