Chicago Public Schools
OFFICE FOR STUDENTS WITH DISABILITIES
EMAIL osd@cps.edu
PHONE (773) 553-1800
MAIL 42 W. Madison St.
Chicago, IL 60602

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 ____ Vision ____Hearing ____Swallowing ____Incontinence

Is student toilet trained? ____Yes ____No
Can the student negotiate stairs: ____Yes ____No Comments: _____
Regular physical education: ____Yes ____No If no, modified physical education: ____Yes _____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