NSSEO
Building a Promising Future for Students

# Physician Referral for School Based Occupational/Physical Therapy

**To be completed annually (or as often as needed for medical changes)**

**Student Legal First/Last Name:** _____

**Student Date of Birth:** _____ **Parent Name:** _____

**E-mail or Phone:** _____ **School:**_____

**District of Residence:** _____ **Therapist(s) Name:**_____

**OT and/or PT services in public education are limited to services which are necessary to enable a child to benefit from their educational program. Students who receive occupational and/or physical therapy have been determined eligible for these services as documented on their Individualized Education Program (IEP). Please make any recommendations with this in mind.**

1. Medical Diagnosis: _____

2. Precautions/Contraindications: _____

3. Additional Medical Info (surgery; equipment; medications):_____

**This student has been referred for _____ OT _____ PT Evaluation(s) and services.**

**Ordering/Referring Practitioner Name:** (please print) _____

**Ordering/Referring Practitioner Signature:** _____

**Date of Signature:** _____

**Ordering/Referring Practitioner NPI #** _____

## Ordering/Referring Practitioner OFFICE STAMP:

***Please return by FAX: 847-463-8289 or E-mail: dskoskie@nsseo.org***