Building a promising future for students
NSSEO
Northwest Suburban Special Education Organization
Judith A. Hackett Ed.D., Superintendent

Physician Referral for School Based Occupational/Physical Therapy

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

Student:_____ **Date Of Birth:**_____ **School Year:**_____
School:_____ **District #**_____

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. Adaptive Equipment Presently Used: _____

4. Splints/Orthosis Presently Used: _____

5. Medications: _____

6. Other: _____

This student has been referred for __OT __PT Evaluation(s) and services.

Physicians Name: (please print) _____ **Phone:**_____
Physician's Signature: _____ **Date:**_____

Please return by mail or fax to: