NSSEO REFERRAL for AUTHORIZATION FOR RELATED SERVICES
VISION (TVI, O&M, ADL), OT, PT, APE

Please complete on all new students entering the district with an existing IEP, which the IEP team has accepted. Please forward to the administrative representative for signature to initiate services.

Student Name _____ Birthdate _____District _____

Address _____ City_____ Zip code _____

Parent/Guardian _____ Home Phone _____ Work Phone _____

School _____ Grade _____ Teacher_____

Building Contact Person _____ Title_____ Phone _____

Current Program: ___ Regular Education ___ Other: _____

Current Disability or Medical Diagnosis: (if known)_____

SERVICE AUTHORIZATION

VISION – TEACHER OF THE VISUALLY IMPAIRED:*
Direct _____ # of IEP Minutes per _____ Consultation _____ # of IEP Minutes per _____

VISION – ORIENTATION & MOBILITY:*
Direct _____ # of IEP Minutes per _____ Consultation _____ # of IEP Minutes per _____

VISION – REHABILITATION (ACTIVITIES OF DAILY LIVING):*
Direct _____ # of IEP Minutes per _____ Consultation _____ # of IEP Minutes per _____

OCCUPATIONAL THERAPY:*
Direct _____ # of IEP Minutes per _____ Consultation _____ # of IEP Minutes per _____

PHYSICAL THERAPY:*
Direct _____ # of IEP Minutes per _____ Consultation _____ # of IEP Minutes per _____

ADAPTED PHYSICAL EDUCATION:*
Direct _____ # of IEP Minutes per _____ Consultation _____ # of IEP Minutes per _____
PE Schedule:
_____

ADDITIONAL COMMENTS (optional):

*PLEASE INCLUDE THE FOLLOWING INFORMATION: Current IEP with goals and objectives, Copy of relevant medical or diagnostic reports, Physician's Prescription for Services (OT and/or PT)

_____ **Building Representative / Date**

_____ **Administrative Representative / Date**