INITIAL PHYSICAL THERAPY REFERRAL REQUEST

Cloverleaf Local School District

STUDENT NAME: _____ DATE OF BIRTH: _____

PARENT(S) NAME: _____ PHONE NUMBER: _____

HOME ADDRESS: _____

SCHOOL: _____ DATE OF REFERRAL: _____

TEACHER: _____ GRADE LEVEL: _____

BUILDING CONTACT/REFERRAL SOURCE: _____

SCHOOL TASK DIFFICULTY (CHECK ALL THAT APPLY)

___ Flexibility/Strength
___ Postural Control/Positioning
___ Balance/Coordination
___ Sensory Motor Processing
___ Functional Mobility Skills
___ Environmental Mobility Skills
___ Gross Motor Skills
___ Physical Education Participation
___Other (list): _____

SERVICE REQUESTED (CHECK ALL THAT APPLY)

___ Student is new to the school district
    ___ Student has active individual education plan that includes physical therapy services
    ___ Student needs mobility and/or gross motor needs in this environment determined
___ Provide one time consultation to address the following concerns (list): _____
_____
___ Provide screening to determine need for physical therapy services
___ Provide comprehensive evaluation as part of a multi-factored evaluation (attach copy of planning form and parent consent)

DATA REQUIRED (CHECK ALL THAT APPLY)

___ Student has a current individual education plan (attach copy of current IEP)
___ Available documentation from another physical therapy and/or medical source is attached
___ Functional Educational Checklist is attached

AUTHORIZATIONS

_____ _____
Director of Student Services Date

I understand the action requested and agree to it being implemented by appropriate district physical therapy personnel.

_____ _____
Parent Signature Date