OT & PT SERVICES PRESCRIPTION REQUEST



|  |  |
| --- | --- |
| For service provider(s) to complete | For Parent/Guardian to complete |

# Notification of PT Services

|  |  |  |
| --- | --- | --- |
|  | PHYSICAL THERAPIST | OCCUPATIONAL THERAPIST |
| Name: |  |  |
| Phone: |  |  |
| Email: |  |  |
| PT Signature: |  |  |
| Date: |  |  |

This is to notify the physician of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (DOB: \_\_\_\_\_\_\_\_\_\_\_), that he/she is receiving physical therapy services in the school environment. At your earliest convenience, a referral for PT services is appreciated. Please review, sign, and return the form below. Thank you in advance.

Physical Therapy (PT) and Occupational Therapy (OT) programs in educational settings may include but are not limited to the areas of developmental motor skills, functional mobility, self-care, and sensory/perceptual motor skills. This therapy is provided for exceptional students whose deficits require therapeutic intervention if the students are to benefit from their educational program.

# Prescription for Physical Therapy and Occupational Therapy

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Patient Name: |  |  | DOB: |  |  | Physician Comments: |
| Diagnosis: |  |  |
| Precautions / Contraindications: |  |  |

I recommend the above named patient receive physical therapy and occupational therapy within the school environment.

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| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| Physician’s Signature |  | NPI (required) |  | Date |

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| --- | --- | --- | --- |
| PHYSICIAN, PLEASE FAX THIS REFERRAL FORM TO: |  |  |  |
|  | Fax No. |  | Attn: |
| ***Do not cut • Return entire form to service provider • Do not cut • Return entire form to service provider • Do not cut • Return entire form to service provider*** |

# Parent/Guardian Authorization for Release/Exchange of Information

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (*name of parent/guardian*) authorize the exchange of communications and the release/exchange of the following records or confidential information and/or communications concerning \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(student name)* DOB: \_\_\_\_\_\_\_\_\_\_\_\_, (hereinafter “the student”) between the Cooperative Association for Special Education (“C.A.S.E.”), its agents and employees and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(physician name/agency) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (phone number)* and his/her agents and employees: Individualized Education Plans, progress reports, health history, medical reports, and information pertaining to OT and/or PT. These disclosures are authorized pursuant to 20 U.S.C. Section 1232g, 105 ILCS 10/1 *et seq*., and 740 ILCS 11/01 *et seq*.,\* and are to be made for the purpose of continuity of care as it pertains to OT and/or PT. I understand that I have the right to inspect and copy the records and information to be disclosed, challenge their contents, and limit my consent to designated records or portions of the information or communications contained in those records. I also understand that my refusal to consent to the exchange of records and communications could result in a delay of OT and/or PT services.

This Authorization expires one year from the date indicated below. However, I understand that I have the right to revoke this consent in writing at any time.

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| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |
| Parent/Guardian Signature |  | Date |  | Student Signature |  | Date |
| *(if student is less than 18 years)* |  |  |  | *(for developmental disability records if student is age 12 or older, but less than 18 years)* |  |  |
|  |  |  |  |  |  |  |
| Witness Signature |  | Date |  |  |  |  |
| *(for developmental disability records)* |  |  |  |  |  |  |

\*NOTE: Prior to the release of protected health information, health care providers may require the parent/guardian to execute an additional authorization form to comply with the Health Insurance Portability and Accountability Act (“HIPAA”).

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| --- | --- | --- |
| PLEASE NOTE THAT DURING THE PERIOD OF ANY “SHELTER-IN” ORDER ISSUED BY THE GOVERNOR, OR IF YOU ARE OTHERWISE UNABLE TO LEAVE YOUR HOME DURING THE SCHOOL CLOSURE PERIOD, YOU MAY TAKE A PICTURE OF THIS SIGNED FORM ON YOUR CELL PHONE AND E-MAIL IT TO THE SERVICE PROVIDER AT: | Name: |  |
| Email: |  |
| Title: |  |

ALTERNATIVELY, IF YOU ARE UNABLE TO PRINT THIS AGREEMENT TO SIGN AND SEND, YOU MAY E-MAIL THE ABOVE SERVICE PROVIDER AND STATE THE FOLLOWING: “We are unable to print this Agreement to sign manually, so please treat this e-mail as our Agreement in full.”

 OT & PT SERVICES PRESCRIPTION REQUEST

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| --- | --- |
| For service provider(s) to complete | For Parent/Guardian to complete |

# Notification of PT Services

|  |  |  |
| --- | --- | --- |
|  | PHYSICAL THERAPIST | OCCUPATIONAL THERAPIST |
| Name: |  |  |
| Phone: |  |  |
| Email: |  |  |
| PT Signature: |  |  |
| Date: |  |  |

This is to notify the physician of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (DOB: \_\_\_\_\_\_\_\_\_\_\_), that he/she is receiving physical therapy services in the school environment. At your earliest convenience, a referral for PT services is appreciated. Please review, sign, and return the form below. Thank you in advance.

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# Prescription for Physical Therapy and Occupational Therapy

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Patient Name: |  |  | DOB: |  |  | Physician Comments: |
| Diagnosis: |  |  |
| Precautions / Contraindications: |  |  |

I recommend the above named patient receive physical therapy and occupational therapy within the school environment.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| Physician’s Signature |  | NPI (required) |  | Date |

|  |  |  |  |
| --- | --- | --- | --- |
| PHYSICIAN, PLEASE FAX THIS REFERRAL FORM TO: |  |  |  |
|  | Fax No. |  | Attn: |
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# Parent/Guardian Authorization for Release/Exchange of Information

Yo \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(nombre del padre/guardián) autorizo el intercambio de comunicación y el lanzamiento/intercambio de los siguientes archivos o información confidencial y/o comunicación sobre \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(nombre del estudiante) Fecha de nacimiento: \_\_\_\_\_\_\_\_\_\_\_\_\_\_, (en adelante “el estudiante”) entre la Cooperative Association for Special Education (“C.A.S.E.”), sus agentes y empleados y \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (nombre del médico/agencia)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (número de teléfono ) y sus agentes y empleados: Plan Educativo Individualisado, reporte del progreso, historia de salud, reportes medicos, y informacion perteneciente a TP y/o TO. Esta revelacion esta autorizado de conformidad a 20 U.S.C. Section 1232g, 105 ILCS 10/1 et seq., y 740 ILCS 11/01 et seq.,\* y es para ser echo en proposito de continuedad de cuidado en lo que se refiere a TP y/o TO. Yo entiendo que tengo el derecho de inspeccionar y aser copias de archivo y informacion que va hacer revelada, desafiar su contenido, y limitar mi consentimiento a los registros designados o porciones de la información o comunicación contenidos en los archivos. Yo tambien entiendo qe mi rechazo para consenter el intercambio de archivos y comunicación puede resultar en el retraso de TP.

Esta Autorización se expira un año de la fecha indicada abajo. Sin embargo yo entiendo que yo tengo el derecho de revocar este consentimiento por escrito en cualquier momento.

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|  |  |  |  |  |  |  |
| Firma de Padre/Guardián |  | Fecha |  | Firma de Estudiante |  | Fecha |
| *(si el estudiante tiene menos de 18 años)* |  |  |  | *(para el arhivo de discapacidad del Desarrollo si el estudiante tiene 12 o mas, pero menos de 18 años)* |  |  |
|  |  |  |  |  |  |  |
| Firma de Testigo |  | Fecha |  |  |  |  |
| *(si el estudiante tiene menos de 18 años)* |  |  |  |  |  |  |

\*NOTE: Prior to the release of protected health information, health care providers may require the parent/guardian to execute an additional authorization form to comply with the Health Insurance Portability and Accountability Act (“HIPAA”).

|  |  |  |
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| POR FAVOR NOTE QUE DURANTE EL PERIODO DE CUALQUIER PEDIDO DE "REFUGIO" EMITIDO POR EL GOVERNADOR, O SI DE OTRA MANERA NO PUEDE SALIR DE SU CASA DURANTE EL PERIODO DE CIERRE DE ESCUELA, USTED PUEDE TOMAR FOTOGRAFIA DE ESTE FORMULARIO FIRMADO EN SU TELEFONO CELULAR Y ENVIARLO POR CORREO ELECTRONICO AL PROVEEDOR DE SERVICIOS A: | Nombre: |  |
| Correo Electronico: |  |
| Titulo: |  |

ALTERNATIVAMENTE, SI NO PUEDE IMPRIMIR ESTE ACUERDO PARA FIRMAR Y ENVIAR, PUEDE ENVIAR UN CORREO ELECTRONICO AL PROVEEDOR DEL SERVICIO ANTERIOR Y DECIR LO SIGUIENTE: "No podemos imprimir este Acuerdo para firmarlo manualmente, asi que trate este correo electronico como nuestro Acuerdo completo".