CASE
excellence through collaboration
22W600 Butterfield Road
Glen Ellyn, IL 60137-6957
Mary M. Furbush, Ed.D.
Executive Director
630-942-5600, Relay Service 711
Fax 630-942-5601

NOTIFICATION OF OT SERVICES

This is to notify the physician of _____, that he/she is receiving Occupational Therapy services in the school environment. At your earliest convenience, a referral for OT services is appreciated. Please review, sign, and return the form below. Thank you in advance.

_____ _____
Therapist signature *Date*

OCCUPATIONAL THERAPY PRESCRIPTION

PATIENT NAME: _____ **DOB**: _____
ADDRESS: _____ **PHONE**: _____

DIAGNOSIS: _____

PRECAUTIONS/CONTRAINDICATIONS: _____
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.

THERAPIST CONTACT INFO: *phone:* *email*:

PHYSICIAN COMMENTS: _____

_____

I recommend the above named patient receive Occupational Therapy within the school environment.

_____ _____ _____
Physician's Signature *NPI (required)* *Date*

PHYSICIAN, PLEASE FAX THIS REFERRAL FORM TO
_____
ATTN: _____

Do not cut. . . . Return entire form to OT. . . . . Return entire form to OT. . . . Do not cut.

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 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.

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

_____ _____
Witness Signature *(for developmental disability records)* Date

*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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Therapist signature *Date*

OCCUPATIONAL THERAPY PRESCRIPTION

PATIENT NAME: _____ **DOB**: _____
ADDRESS: _____ **PHONE**: _____

DIAGNOSIS: _____

PRECAUTIONS/CONTRAINDICATIONS: _____
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THERAPIST CONTACT INFO: *phone:* *email*:

PHYSICIAN COMMENTS: _____

_____

I recommend the above named patient receive Occupational Therapy within the school environment.

_____ _____ _____
Physician's Signature *NPI (required)* *Date*

PHYSICIAN, PLEASE FAX THIS REFERRAL FORM TO
_____
ATTN: _____

Do not cut. . . . Return entire form to OT. . . . . Return entire form to OT. . . . Do not cut.

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.

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

_____ _____
Firma de Testigo *(para el archive de discapacidad del desarrollo)* Fecha

*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").