

**NOTIFICATION OF OT AND PT SERVICES**

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

\_\_\_\_\_  
*Therapist signature*

\_\_\_\_\_  
*Date*

**PRESCRIPTION FOR OCCUPATIONAL THERAPY AND PHYSICAL THERAPY**

**PATIENT NAME:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**PHONE:** \_\_\_\_\_

**DIAGNOSIS:** \_\_\_\_\_

**PRECAUTIONS/CONTRAINDICATIONS:** \_\_\_\_\_

Therapy 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.

**PHYSICAL THERAPIST CONTACT INFO:**

*phone:*

*email:*

**OCCUPATIONAL THERAPIST CONTACT INFO:**

*phone:*

*email:*

**PHYSICIAN COMMENTS:** \_\_\_\_\_

I recommend the above named patient receive occupational therapy and physical 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 PT. . . . .

. . . . . Return entire form to PT. . . . . 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 PT and/or OT. 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 PT and/or OT. 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 PT and/or 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*

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**DOB:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**PHONE:** \_\_\_\_\_

**DIAGNOSIS:** \_\_\_\_\_

**PRECAUTIONS/CONTRAINDICATIONS:** \_\_\_\_\_

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*phone:*

*email:*

**OCCUPATIONAL THERAPIST CONTACT INFO:**

*phone:*

*email:*

**PHYSICIAN COMMENTS:** \_\_\_\_\_

I recommend the above named patient receive occupational therapy and physical 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 PT. . . . .

. . . . . Return entire form to PT. . . . . 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 de 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 Individualizado, reporte del progreso, historia de salud, reportes medicos, y información 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 continuidad 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 informacion o comunicacion contenidos en los archivos. Yo tambien entiendo que mi rechazo para consenter el intercambio de archivos y comunicacion puede resultar en el retraso de TP y/o TO.

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 years)*

\_\_\_\_\_  
*Fecha*

\_\_\_\_\_  
*Firma del Estudiante*  
*(para el archivo de discapacidad del desarrollo si el estudaante tiene 12 o mas, pero menos de 18 años)*

\_\_\_\_\_  
*Fecha*

\_\_\_\_\_  
*Firma de Testigo*  
*(para el archivo de discapacidad del desarrollo)*

\_\_\_\_\_  
*Fecha*

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