CASE
excellence through collaboration

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PHYSICIAN'S REFERRAL FOR PHYSICAL THERAPY

NAME: _____ BIRTHDATE: _____

PARENT/GUARDIAN/SURROGATE: _____ PHONE: _____

HOME ADDRESS: _____ CITY: _____

SCHOOL: _____ PROGRAM: _____

Therapy programs in education 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.

If there are any questions concerning the therapy evaluation or treatment, please contact your assigned therapist.

_____

_____

_____ _____ _____
(School) (Phone) (Therapist's signature)

PHYSICIAN: Please complete the items below and return this form in the enclosed envelope.

Medical diagnosis and/or Description of Concerns: _____

_____

Current Medication: _____

Precautions or Contraindications: _____

Assistive Devices: _____

Comments: _____

_____

_____ _____ _____
(Physician's Name) (Address) (Phone)

I recommend the above named student receive Physical Therapy.

_____ _____
(Physician's Signature) NPI (Required) (Date)

First mailing _____
Second mailing _____
Third mailing _____

The Cooperative Association for Special Education (CASE) is a 21st century organization that collaborates to provide special education services and support for students in our member districts.