Physical / Occupational Therapy Request

FORM MUST BE COMPLETED BEFORE EVALUATION / THERAPY CAN BEGIN

Student's Full Name: _____ Date of Birth: _____

Grade: _____ School: _____ Year: _____ SS#:_____

Teacher(s): _____

Insurance: ☐ Medicaid ☐ PeachCare ☐ Private Insurance _____

(**If Medicaid or PeachCare, Please ATTACH COPY of card.)**

Does student receive physical/occupational/speech therapy anywhere else? ☐ Yes ☐ No

If yes, please list the agency and his/her schedule. _____

Parent/Guardian Name: _____

Address: _____

Phone: _____

Major Health Problems/Diagnosis: _____

Primary Physician (Doctor): _____Address: _____

Other Physicians or Clinics where student goes for medical care: _____

_____

Ever had surgery? ☐ No ☐ Yes If yes, What and When? _____

_____

Does student need help with: ☐ Feeding ☐ Self-Help Skills ☐ Mobility ☐ Handwriting ☐ Sensory ☐ Other school related activity EXPLAIN: _____

_____

Student has goal in IEP working towards issue noted above ☐ Yes ☐ No

Student is making progress toward goal(s) in IEP ☐ Yes ☐ No

Check each **Educationally Significant Challenging Condition** that you believe this student has

☐ Orthopedic Disorder ☐ Visual Impairment ☐ Mental Impairment ☐ Cerebral Palsy

☐ Hearing Impairment ☐ Emotional Disorder ☐ Heart Disorder ☐ Muscular Dystrophy

☐ Learning Disability ☐ Autism / PPD ☐ Other (list) _____

Parent concerns regarding this student's school performance: _____

_____