Icon

Description automatically generated

AIU Date Received\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax  E-mail

# PHYSICAL / OCCUPATIONAL THERAPY SERVICES REFERRAL FORM

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**PA SECURE ID#:**

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|  |

**DATE OF REFERRAL:**

|  |
| --- |
|  |

**HOME SCHOOL DISTRICT:**

**REFERRAL INITIATED BY:**  Team  Teacher  Parent  Other

# SERVICE REQUESTED: Physical Therapy Occupational Therapy

# Sensory Only

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **SPECIAL EDUCATION STUDENT** | | | **REGULAR EDUCATION STUDENT** | | |
| EvaluationIn Progress  Existing IEP  Screening Only | | | First Referral (Screening only)  Second Referral (Full Evaluation)  Existing 504 (Full Evaluation) | | |
|  | | |  | | |
| **TRANSFER STUDENT** | | | **PRE-K STUDENT (EI DEFERRED)** | | |
| From:  Date of Transfer:  (Attach Current OT/PT IEP OR 504 Goals and Frequency) | | |  | | |
|  | | |  | | |
| **Student**  **Last Name:** | **First Name:** | | | **DOB:** |
| **School Student Attends:** | | | | **Grade:** |
| **School District Where**  **School Is Located:** | | **School Contact Person:** | | |
| **District Contact Phone #:** | | **Contact Email:** | | |
| **Parent Name:** | | **Parent Phone #:** | | |
| **Address:** | | **Parent E-Mail Address #:** | | |
| **City/Zip:** | | **Additional Comments:** | | |

**\*\*REVIEWED BY DISTRICT LIAISON: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*\***Your signature on this form indicates approval and that an active Permission to Evaluate has been obtained if required.

This form can be emailed as an attachment to: [natalie.krall@aiu3.net](mailto:natalie.krall@aiu3.net) or faxed to attn.: OT/PT: (412) 394-4978. If you have any questions, please feel free to call Holly McElhinny at: (412) 394-5503.