

 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 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.