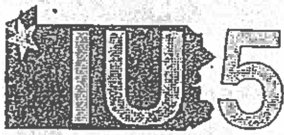

OT

NORTHWEST TRI-COUNTY INTERMEDIATE UNIT

252 Waterford Street, Edinboro, Pennsylvania 16412-2315
PHONE 814-734-5610
1-800-677-5610
FAX 814-734-5806
TTD 814-734-1098
http://www.iu5.org

REFERRAL for RELATED OT/PT SERVICES

OT Screening Completed? Yes ☐ No ☐ Therapist name/Phone: ____________
PT Screening Completed? Yes ☐ No ☐ Therapist name/Phone: ____________

Dear Parent/Guardian,

The screening team recommended your child receive an evaluation by the school-based Occupational and/or Physical Therapist. Please review and complete the attached parent form. In order for direct therapy to occur, if recommended from the evaluation, we ask that you obtain a prescription from your physician. To do this, please have your physician/CRNP complete section #3 and return this form to the school's supervisor of special education. We cannot provide direct therapy without a prescription. Thank you for your assistance.

1. *Demographic data –PARENT/ GUARDIAN, Please complete any missing data.*

Child's Name: ____________ Telephone (H): ____________
Parent/Guardian: ____________ Telephone (C): ____________
Street Address: ____________ DOB: ____________
City/State/Zip: ____________ Grade: ____________
District of Residence: ____________

Current/ Previous Agency & Therapist Name: (Please attach any Medical, OT or PT reports)
____

Reason for Referral: ____________

2. Teacher's Name: ____________ Attending District/Building: ____________
If preschool: Days/times: ____________ Teacher Phone #: ____________

Requesting: ☐ Occupational Therapy Evaluation (fine motor) ☐ Physical Therapy Evaluation (gross motor)

TEACHER: Please send this request via your district procedure to the Intermediate Unit secretary for OT/PT services.

3. ***Health Care Provider Approval for Treatment:***
Dear Doctor: The student listed above, a patient of yours, has been recommended for an evaluation to determine if occupational and/or physical therapy as a related service in school is appropriate. Our policy dictates we obtain a prescription/order before direct services occur to rule out any adverse effects treatment may cause.

Physician or CRNP Name (Printed): ____________ Phone #: ____________
Physician's Signature: ____________ Date: ____________
Address: ____________

Child's Medical Diagnosis: ____________
Medications or N/A: ____________
Precautions or N/A: ____________

My signature above indicates that I prescribe the student listed above can receive school-based Occupational and/or Physical Therapy services as recommended by the Individual Education Program team. I understand that related services are provided to help children access their educational environment and materials and are not for rehabilitation purposes

Date given to therapist: ____________ Therapist name(s): ____________

PERMISSION TO EVALUATE (PTE) - CONSENT FORM

School Age

School Personnel must issue this form to obtain written consent from a child's parent to conduct an initial evaluation.

Child's Name: ____________________

Date Sent (mm/dd/yy): ____________

Name and Address of Parent/Guardian/Surrogate:

____

____

____

____

For LEA Use Only:
Date of Receipt of Consent Form

Dear ____________________ :

The following concerns have been expressed about your child's educational progress:

O.T.

Difficulty with manipulation of materials necessary for performing school functions such as: paper, pencil; visual/spatial orientation and closure, figure ground; and scissor activities.

These difficulties are the reason(s) for referral, and why we would like to conduct an initial evaluation to determine if your child is in need of special education services.

The first step in the special education process is to conduct an individual evaluation of your child, which will consist of a variety of tests and assessments provided at no cost to you. We must have your consent before we can begin.

The evaluation will consist of the following types of tests and assessments:

Teacher/staff interview, observation, file review, standardized gross and fine motor tests, tests of perceptual ability, student interview, parent interview.

A team will conduct the proposed evaluation. As the parent(s), you are a member of the team. Any information you can provide is important to us. Please send your ideas and concerns to us in writing or contact the person listed below if you would prefer to discuss your concerns. If a team meeting is held you will be invited. Information from all team members will be considered during the evaluation process.

The team will determine whether your child needs specially designed instruction because of a disability and is eligible for special education. The results of the evaluation will be included in an *Evaluation Report (ER)*. If your child *is* determined to be eligible for special education, you will be invited to participate in developing an *Individualized Education Program (IEP)* that will include those programs and services your child needs to succeed in school.

The *Evaluation Report* must be completed and a copy given to you no later than 60 calendar days after we have received your written permission for the evaluation. This 60 calendar day timeline does not include the summer break. The 60 calendar day timeline will begin on the day we receive this signed *PTE - Consent Form* from you giving your consent for evaluation. Giving your consent for evaluation does not mean you give consent to special education placement or services. If your child is eligible for special education, you will be asked to give written consent for services to begin.

Please read the enclosed *Procedural Safeguards Notice* that explains your rights, and includes state and local advocacy organizations that are available to help you understand your rights and how the special education process works.

PERMISSION TO EVALUATE - CONSENT FORM
Child's Name:

Keep a copy of this form for your records.

If you have any questions, or if you need the services of an interpreter, please contact me.

Name: ______________________ Position: ______________________

Phone: ______________________ Email: ______________________

DIRECTIONS FOR PARENT/GUARDIAN/SURROGATE: Please check either item 1 or 2. Select item 3 if desired.

1. ☐ I give consent to start an initial evaluation as you propose.
2. ☐ I do not give consent to the proposed initial evaluation.
3. ☐ I would like to schedule an informal meeting with school personnel to discuss this request.

SIGN HERE:

______________________ ______________________ ______________________

Parent/Guardian/Surrogate Signature Date (mm/dd/yy) Daytime Phone

PLEASE RETURN THIS ENTIRE FORM TO:

Name: ______________________

Address: ______________________

____

____

For help in understanding this form, an annotated *Permission to Evaluate - Consent Form* is available on the PaTTAN website at www.pattan.net Type "Annotated Forms" in the Search feature on the website. If you do not have access to the Internet, you can request the annotated form by calling PaTTAN at 800-441-3215.

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REASON for OT and/or PT Referral *(Parent Form)*

Child's Name: ____________________

Date: ____________________

Parent Signature: ____________________

Major Concerns:

What are your specific concerns regarding your child's ability to be successful in their preschool or school environment?

____

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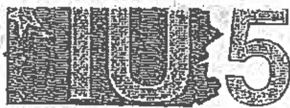
Put an X in front of the items that are related to your concerns:

☐ Fine Motor/Occupational Therapy Concerns	☐ Gross Motor/Physical Therapy Concerns
Problems with: ☐ Toileting ☐ Eating ☐ Dressing ☐ Other (describe):	**Problems with:** ☐ Toileting ☐ Seating ☐ Safety ☐ Other (describe):
Difficulty with: ☐ Abnormal pencil grip ☐ Jerky or unsteady motion when drawing, writing, tracing ☐ Difficulty cutting ☐ Inconsistent hand dominance ☐ Other (describe):	**Difficulty with:** ☐ Standing ☐ Running ☐ Walking ☐ Stair climbing ☐ Falling frequently ☐ Wheelchair dependent ☐ Other (describe):

Occupational or Physical Therapy Concerns:

- ☐ Avoids using one side of body
- ☐ Avoids messy tasks (e.g. gluing, clay, finger painting)
- ☐ Excessive touching
- ☐ Fearful of movement: ☐ Stairs ☐ Slides ☐ Swings
- ☐ Objects to being touched (cuddled, hugged)
- ☐ Other (describe):

An Equal Rights And Opportunities Employer



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REASON for OT and/or PT Referral *(Teacher Form)*

Child's Name: ____________________

Date: ____________________

Teacher's Signature: ____________________ Room #: ________

Major Concerns:

Identify your specific concerns regarding the student's ability to function in their preschool or school environment.

____

____

____

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____

Which of the following supports your concerns? (Put an X in front of all that apply.)

The following sections must be completed for a Physical Therapy assessment.

1. GROSS MOTOR

- ☐ Unusual standing, walking, running posture
- ☐ Balance problems (falls frequently)
- ☐ Difficulty moving from one position to another
- ☐ Poor locomotor skills (stair climbing, indoor walking, and outdoor walking)
- ☐ Poor sitting balance (posture control, head control, trunk control)
- ☐ Uses wheelchair or assistive device (walker, crutch, cane)
- ☐ Other ______________________________

Physical Education Teacher: ______________________________

Physical Education Class Time/Day: ______________________________

2. SELF HELP

Problems with:

- ☐ Toilet
- ☐ Seating
- ☐ Safety (bus, entering/exiting the school, playground)
- ☐ Other (describe):

REASON for OT and/or PT Referral *(Teacher Form), cont.*

Additional Comments/Student Strengths:

____

____

____

The following sections must be completed for an Occupational Therapy Assessment.

1. FINE MOTOR/VISUAL MOTOR

- ☐ Abnormal grip of manipulatives (toys, crayons, pencils)
- ☐ Fatigues with lengthy written output
- ☐ Poor motor control when drawing, writing, tracing, cutting (i.e. tremor)
- ☐ Decreased upper body strength
- ☐ Inconsistent hand dominance
- ☐ Visual motor skills are not commensurate with cognitive ability
- ☐ Other (describe): _______________________

2. VISUAL PERCEPTUAL

- ☐ Confusion with directional concept (up, down, right, left)
- ☐ Difficulty copying from: ☐ blackboard ☐ book ☐ worksheet
- ☐ Reverses letters, numbers, words, phrases (beyond 2nd grade)
- ☐ Difficulty discriminating colors, shapes, size
- ☐ Poor sequencing of: ☐ patterns ☐ tasks ☐ art projects
- ☐ Poor eye tracking while reading, playing
- ☐ Poor organization of work on the page
- ☐ Other (describe): _______________________

3. SENSORY

- ☐ Toileting
- ☐ Eating
- ☐ Dressing
- ☐ Avoids using one side of body
- ☐ Avoids messy tasks (e.g. gluing, clay, finger painting)
- ☐ Other: _______________________

Additional Comments/Student Strengths:

____

____

____

Pre-Referral Strategies Tried:

____

____

____