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READS Collaborative

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REFERRAL FORM FOR OCCUPATIONAL THERAPY / PHYSICAL THERAPY / SENSORY INTEGRATION / ADAPTED PHYSICAL EDUCATION / SPEECH AND LANGUAGE

STUDENT'S NAME_____AGE_____D.O.B._____SEX___M___F

PARENT/GUARDIAN*_____RELATIONSHIP_____

HOME ADDRESS_____HOME PHONE_____

***If guardian or in custody of D.S.S., please attach court order to this effect.**

REFERRING DISTRICT_____

SPECIAL EDUCATION DIRECTOR AUTHORIZATION_____

REFERRED BY_____POSITION_____PHONE_____

SCHOOL_____TEACHER_____GRADE_____AM/PM

THIS REFERRAL IS FOR: OT INITIAL EVALUATION_____OT 3 YR RE-EVALUATION_____SENSORY INTEGRATION_____
PT INITIAL EVALUATION_____PT 3 YR RE-EVALUATION_____
APE INTIAL EVALUATION_____APE 3 YR RE-EVALUATION_____
SPEECH AND LANGUAGE INITIAL EVALUATION_____ SPEECH AND LANGUAGE 3 YR RE-EVALUATION_____

***REASON FOR REFERRAL:**_____

_____

(*Please give a reason and please be specific – additional space located on last page)

PRESENT PLACEMENT (CHECK ONE):

_____a. Regular Program
_____b. Regular Program with modification (please specify modification)_____
_____c. Regular Program with special help out of classroom (please specify nature of special help and name of tutor/specialist)_____
_____d. Substantially separate program (briefly describe type of special need)_____
_____
_____e. IEP prescription for OT - IEP Date_____ SERVICE DELIVERY FREQUENCY_____
IEP prescription for PT - IEP Date_____SERVICE DELIVERY FREQUENCY_____

(please be specific – attach separate sheet if necessary)

IS CHILD PRESENTLY RECEIVING OT, PT, APE and/or SPL SERVICES THROUGH READS? _____YES _____ NO – IF NO,

OTHER? (please specify)_____

_____

READS Collaborative's mission is to provide creative, flexible solutions that promote the success and well-being of each child, adolescent and adult learner.

STUDENT'S NAME_____ REFERRING DISTRICT_____

PARENT RELASE

I, as parent or guardian, hereby give consent for READS to conduct an Occupational Therapy/Physical Therapy/ Sensory Motor Integration/Adapted Physical Education and/or Speech and Language Evaluation(s) on the above named child. I understand that the results of these evaluations will be shared with the public school named above. I also give my consent for the READS staff to review any school records as deemed necessary to carry out the requested evaluation(s).

Signature: _____ Relationship: _____ Date: _____

In addition, I give permission to the staff at READS to contact my family physician (named below) for relevant medical information. In turn, I understand that copies of medical records will be sent to my family physician.

Signature: _____ Relationship: _____ Date: _____
Name of family physician: _____
Address: _____Phone:_____

In addition, I give permission to the staff at READS to contact my child's most recent private therapist (if any) named below for relevant information.

Signature: _____ Relationship: _____ Date: _____
Name of private therapist: _____
Address: _____Phone: _____

PARENT INFORMATION

Child/Adolescent's problems as seen by a parent (**please be specific**):_____

_____

_____

_____

_____

Child/adolescent crawled at _____months.

Child/adolescent walked alone at _____months.

Child/adolescent spoke single words at _____months.

STUDENT'S NAME: _____ REFERRING DISTRICT: _____

MEDICAL HISTORY

_____ Anoxia _____

_____ Allergies _____

_____ Asthma _____

_____ Birth Defects _____

_____ Convulsions / Seizures _____

_____ Emotional Problems _____

_____ Feeding Problems _____

_____ Heart Disease _____

_____ Premature at Birth _____

_____ Recurring Infections (i.e. ear, throat) _____

_____ Scoliosis _____

_____ Speech Problems _____

_____ Surgeries / Hospitalizations _____

_____ Other _____

Does child wear BRACES or SPLINTS? _____ No _____ Yes – If yes, explain _____

_____

Does child have EYE PROBLEMS INCLUDING VISION AND GLASSES? _____ No _____ Yes – If yes, explain _____

_____

Pleases list MEDICATIONS child is currently taking or has previously taken.

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please explain OTHER PERTINENT MEDICAL INFORMATION below:

_____

_____

_____

STUDENT'S NAME _____ REFERRING DISTRICT _____

REFERRAL INFORMATION***

Please give a brief explanation as to the reason for referring child for an Occupational Therapy / Physical Therapy / Sensory Motor Integration / Adapted Physical Education and/or Speech and Language Evaluation(s) (i.e. for example, what impedes classroom performance). Please summarize specific concerns relative to child's performance.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

***** PLEASE GIVE A SPECIFIC REASON FOR REFERRAL – ESPECIALLY IF AN INITIAL EVALUATION IS BEING REQUESTED. IT HELPS THE THERAPIST TO DETERMINE WHAT MATERIALS WILL BE NECESSARY FOR TESTING.**