

Referring School: _____
 School phone number: _____
 School fax number: _____

Physician's Referral for Occupational and/or Physical Therapy

Child's Name: _____	Date of Birth: _____
Home Address: _____	Telephone: _____
Student ID #: _____	Grade: _____
	School: _____

(To be completed by physician, a delegated physician assistant or an advanced practice nurse collaborating with a physician.)

Medical Diagnosis/History (seizures, etc): _____	ICD-10 Code _____												
Precautions & Contraindications: _____													
Recent surgeries or changes in condition (please include weight bearing status): _____													
Current Medications/Dosage/Frequency: _____													
Wheelchair/Equipment Needs: _____													
Check if current problem: <input type="checkbox"/> vision <input type="checkbox"/> hearing <input type="checkbox"/> swallowing <input type="checkbox"/> Incontinence													
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;">Is student toilet trained?</td> <td style="width: 10%; text-align: center;">__ YES</td> <td style="width: 10%; text-align: center;">__ NO</td> <td style="width: 50%;"></td> </tr> <tr> <td>Can student negotiate stairs:</td> <td style="text-align: center;">__ YES</td> <td style="text-align: center;">__ NO</td> <td>Comments:</td> </tr> <tr> <td>Regular physical education:</td> <td style="text-align: center;">__ YES</td> <td style="text-align: center;">__ NO</td> <td>If no, modified physical education: <input type="checkbox"/> YES <input type="checkbox"/> NO</td> </tr> </table>		Is student toilet trained?	__ YES	__ NO		Can student negotiate stairs:	__ YES	__ NO	Comments:	Regular physical education:	__ YES	__ NO	If no , modified physical education: <input type="checkbox"/> YES <input type="checkbox"/> NO
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COMPLETE ONLY RELEVANT SECTION(S)

(To be completed by physician, a delegated physician assistant or an advanced practice nurse collaborating with a physician.)

<p><u>Occupational Therapy Recommendations</u> Evaluate and Treat as appropriate for school-based goals. Comments: _____</p>	_____ National Provider Identifier (NPI) _____ IL Medicaid Provider Number
Physician's Signature: _____	Date: _____
Physician's Name: _____ (print)	Phone: _____
Address: _____	
Hospital Affiliation: _____	

(To be completed by physician, a delegated physician assistant or an advanced practice nurse collaborating with a physician.)

<p><u>Physical Therapy Recommendations</u> Evaluate and Treat as appropriate for school-based goals. Comments: _____</p>	_____ National Provider Identifier (NPI) _____ IL Medicaid Provider Number
Physician's Signature: _____	Date: _____
Physician's Name: _____ (print)	Phone: _____
Address: _____	
Hospital Affiliation: _____	