



PT

252 Waterford Street, Edinboro, Pennsylvania 16412-2315

NORTHWEST TRI-COUNTY INTERMEDIATE UNIT

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 - CONSENT FORM

Child's Name:

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:

P.T.

Gross motor skills related to walking, coordination, seating, muscle strength/flexibility, toileting, and safety traveling in the school setting

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 interviews, 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?

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

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



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.

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:
