School Therapy Services

OT/PT Referral and School Authorization Form

Student Information:

First Name: _____ **Last Name:** _____ **DOB:** _____

School: _____ **School Board:** _____

Requested Service:
Indicate which service you are requesting for your student:

OT		I confirm I have spoken with the STS OT assigned to my school or STS Clinical Coordinator about this referral	
P			

Please indicate areas of need for your student (select all that apply) *

	Sensory
	Fine Motor
	Gross Motor
	Strength, Balance and/or Coordination
	Gym Participation
	Positioning

	Feeding and Swallowing
	Self-Care e.g. toileting
	Safety
	Accessibility and Mobility
	Equipment
	Other – Please Describe Below

MANDATORY: please describe reason for the referral

_____

_____

_____

School Team Information and Authorization

Please Type or Print Legibly:

School Classroom Teacher: _____ Email: _____

School Resource Teacher: _____ Email: _____

School Principal: _____ School Fax Number: _____

School principal or designate has agreed to this referral. (Must be checked)

Family, Legal Guardian, student has agreed to this referral. (Must be checked)

Date	School Principal or Designate	Phone number

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