School Therapy Services

OT/PT Referral and School Authorization Form

Student Information:

First Name: ______________________ **Last Name:** ____________________ **DOB:** ____________

School: __________________________________ **School Board:** ______________________

Recommendation for Individualized Assessment or Support: ☐**OT** ☐**PT** ☐**L1** ☐**L2** ☐**L3**

Observations/Needs:

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Recommended Supports and/or Equipment Assessment:

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Date	**TVCC Therapist (OT, PT, SLP) or Clinical Coordinator**	**Phone number**

School Team Information and Authorization

School Comments (optional)

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Does the student have an Individual Education Plan (IEP)? ☐ Yes ☐No

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**