



Madison-Champaign Educational Service Center

REQUEST FORM FOR OT/PT/APE SERVICE

Service Requested: ☐ OT ☐ PT ☐ APE

- ☐ New Referral
☐ Screening Only

Transfer Student with ☐ OT ☐ PT ☐ APE
currently on the IEP (please attach)

Student Name

Date of Birth

District of Attendance

School Building and Phone Number

District of Residence

Teacher and Room #

End of 60 day Evaluation

Date of Anticipated ETR

Signature of Director/Supervisor of
Special Ed. or the district fiscal rep.

Date

Phone #

Please Note: OT/PT Evaluations **must** be requested through your Director/Supervisor of Special Education or another district fiscal representative. They must sign this form to authorize funding for the evaluation.

Please give a brief description of the main reason for the referral and/or primary concerns:

Please list strategies that have been attempting to address this concern:

