

**MAGOFFIN COUNTY SCHOOLS  
EVALUATION OR SERVICES REQUEST  
FOR**

(Please check one) OT \_\_\_\_\_ or PT \_\_\_\_\_

**Student:** \_\_\_\_\_ **School** \_\_\_\_\_  
**DOB** \_\_\_\_\_ **Grade** \_\_\_\_\_ **Teacher** \_\_\_\_\_

**PLEASE CHECK ONE:**

**Request for Evaluation (Attach Teacher Checklist):**

Referral notes concerns with motor development.

Student is due for a three-year re-evaluation of \_\_\_\_\_.  
(related disability)

Initial Eval

**Request for Therapy:**

Student's current IEP \_\_\_\_\_ identifies  OT or  PT services.  
(date)

**ARC Conference to be conducted on or before** \_\_\_\_\_.  
(date)

**Student's Daily Schedule-** (arrival, co-curricular or specials, recess, lunch, classes (ms/hs), dismissal).

**Classroom Teacher Planning Time (Elem. only)** \_\_\_\_\_

**Special Circumstances that might impact the therapist's interaction with this student** (i.e. attentional issues, attitude or personality, cognitive and language development). **Attach Copy of Previous OT/PT Evaluation.**

**SUBMITTED BY:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

Please complete all applicable sections and fax to Sp. Ed. Dept. @349-6724, and keep original for your records.

Received: \_\_\_\_\_  
(date and initial)