monroe one
EDUCATIONAL SERVICES

Occupational Therapy (OT) and Physical Therapy (PT) Departments

Student Name: ______________________________ **Date of Request:** __________

Please choose all appropriate services, fill in necessary information and include requested documentation.

To assist Monroe One in fulfilling your request, please indicate the reason for referral and any additional information that will help us provide services:

Direct Services

Individual or Group	Frequency (number of sessions)	Duration (minutes per session)	Ratio for Group services

Consultations

OT Consultation Frequency (number of hours per year):

PT Consultation Frequency (number of hours per year):

Evaluations

OT Evaluation (By sending the request, Monroe One assumes consent has been received)

PT Evaluation (By sending the request, Monroe One assumes consent has been received)

Reason for Evaluation(s):

CSE Date/Time or indicate if not scheduled:

Type of OT Evaluation (Initial, Re-Evaluation, IEE):

Type of PT Evaluation (Initial, Re-Evaluation, IEE):

Documentation Requested (if available):

- IEP (services must match the request)
- Previous OT/PT Evaluations
- Current Psychological Evaluation
- Physician Reports
- Current/Pertinent Reports from other domains
- Health Appraisal
- Cross Contract (if a non-component district)

Send cover sheet, request forms, and requested documentation to itinerant@boces.monroe.edu

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