Moss Point School District

Referral for School-Based Physical/Occupational Therapy Evaluation

STUDENT: _____

TYPE OF REFERRAL: _____PHYSICAL _____OCCUPATIONAL

HAS STUDENT PREVIOUSLY RECEIVED OT AND/OR PT? _____YES _____NO

SCHOOL: _____ DATE OF BIRTH:_____

OTHER DIAGNOSIS (Seizures, Tics, Muscle Disorders, etc.): _____

PARENTS/GUARDIAN:_____

HOME ADDRESS: _____

PHONE HOME:_____WORK:_____ CELL_____

DOCTOR'S NAME:_____

FINE MOTOR AND /OR SENSORY CHECKLIST ATTACHED? _____YES _____NO

REASON FOR REFERRAL:_____

_____

_____

OTHER INFORMATION:_____

FOR COMPREHENSIVE REEVALUATIONS:

TYPE OF PROGRAM: _____Inclusion _____Behavior Mod _____Life Skills ____Study Skills

SPED ELIGIBILITY (list subcategories):_____

RELATED SERVICES:_____

LST OR REFERRING SPED TEACHER:_____

DATE:_____