



OCCUPATIONAL & PHYSICAL THERAPY PRE-REFERRAL REQUEST

Date: _____

1. STUDENT INFORMATION

Student:		Birthdate:		Grade:	
Address:	City/State/Zip:				
Parent/Guardian:				Phone:	
Building:	District:				
Referring Teacher:					

2. STUDENT ELIGIBILITY

Is student currently eligible for special education? Yes No If "Yes" what is area of eligibility?

What interventions have been tried for the area of concern?

Other screens or testing that are being requested for this student:

3. AREAS OF CONCERN (Check all that apply)

OCCUPATIONAL THERAPY	<input type="checkbox"/>	Fine Motor	<input type="checkbox"/>	Handwriting		
	<input type="checkbox"/>	Manipulative Skills	<input type="checkbox"/>	Functional Skills		
	<input type="checkbox"/>	Sensory Process	<input type="checkbox"/>	Perceptual Testing		
	<input type="checkbox"/>	Oral Motor/Feeding-(Additional comments MUST be included)				
	<input type="checkbox"/>	Other (Describe)				
Please describe concern:						
PHYSICAL THERAPY	<input type="checkbox"/>	Gross Motor	<input type="checkbox"/>	Ambulation	<input type="checkbox"/>	Orthotics/Braces
	<input type="checkbox"/>	Wheelchair	<input type="checkbox"/>	Coordination		
	<input type="checkbox"/>	Other (Describe)				
	Please describe concern:					

4. PRE-REFERRAL CONSULTATION

Date Pre-Referral Received : _____

Student Observation Results (Provided by NCRESA OT/PT) _____

6. FORMAL REFERRAL

Is a formal referral necessary? Yes No Date: _____

If "yes" OT is requesting the following permission form to be completed: Diagnostic Assessment REED

Date the formal referral was received by the OT or PT _____ Date: _____

Return a copy of this form to the Special Education Supervisor for processing & copy to referring Child Study/SIT coordinator.

Information results from this screening may be used to determine special education eligibility.