CLARKSVILLE MONTGOMERY COUNTY SCHOOL SYSTEM

REFERRAL FOR SERVICES
(Occupational Therapy, Physical Therapy, Vision)

DEMOGRAPHICS

Student's Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Parent/Guardian Name: _____ Phone: _____

Teacher/Program: _____ School: _____

School Phone: _____ School Fax: _____ IEP Date: _____

Referred by: _____ Position: _____

Reason for referral: _____ (Relevant discipline checklist **MUST BE** attached.)

SCHOOL

☐ Initial OT Evaluation ☐ Initial PT Evaluation ☐ Vision Evaluation

☐ OT Re-certification ☐ PT Re-certification

NOTE: ACCORDING TO STATE REGULATIONS WE ARE UNABLE TO PROVIDE OCCUPATIONAL THERAPY AND/OR PHYSICAL THERAPY FOR YOUR CHILD WITHOUT A CURRENT ANNUAL WRITTEN PRESCRIPTION.

NOTE: ACCORDING TO STATE ELIGIBILITY STANDARDS VISION SERVICES MUST HAVE A CURRENT MEDICAL EYE REPORT BEFORE AN ASSESSMENT CAN BE INITIATED.

*****NOTE: Please return completed forms related to therapy services to Psychological Services.**

PARENT

RELEASE OF INFORMATION

☐ I give permission for my child to be evaluated by a related service provider.

☐ A copy of your medical records and/or completion of the attached forms would assist in the evaluation and/or placement of my child.

☐ I authorize CMCSS related service providers and the referring physician to share information as needed. All information obtained will be confidential and pertinent to the treatment of your child. This release will expire one year from signed parent signature.

Parent/Gguardian Signature: _____ Date: _____

PHYSICIAN

NOTE TO EYE CARE SPECIALISTS: PLEASE FILL OUT ATTACHED CMCSS INTER-AGENCY EYE EXAM REPORT

☐ Evaluate and provide educational therapy services as needed.

Diagnosis: _____

Medications: _____

Precautions: _____

Physician Name: _____

Address: _____

Phone: _____ Fax: _____

Physician Signature: _____ Date: _____