School Therapy Services

OT/PT Referral and School Authorization Form

Student Information:

First Name: _____ **Last Name:** _____ **DOB:** _____

School: _____ **School Board:** _____

Requested Service:
Indicate which service you are requesting for your student:

OT		I confirm I have spoken with the STS OT assigned to my school or STS Clinical Coordinator about this referral
PT		

Please indicate areas of need for your student (select all that apply) *

	Sensory
	Fine Motor
	Gross Motor
	Strength, Balance and/or Coordination
	Gym Participation
	Positioning

	Feeding and Swallowing
	Self-Care e.g. toileting
	Safety
	Accessibility and Mobility
	Equipment
	Other – Please Describe Below

MANDATORY: please describe in detail the reason for the referral

_____

_____

_____

School Team Information and Authorization

Please Type or Print Legibly:

School Classroom Teacher: _____ Email: _____

School Resource Teacher: _____ Email: _____

School Principal: _____ School Fax Number: _____

- ☐ School principal or designate has agreed to this referral. (MUST be checked)
- ☐ Family, Legal Guardian, Student has agreed to this referral. (MUST be checked)

Date **School Principal or Designate** **Phone number**

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