



PHYSICIAN'S REFERRAL FOR PHYSICAL THERAPY ASSESSMENT

PRINT STUDENT'S NAME (LAST)	(FIRST)	(M.I.)	STUDENT ID. NO.
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School: _____

Student Information: DOB: _____ Age: _____ Grade: _____ Sex: _____

Name(s) of Parent(s) or Guardian(s): _____ Telephone: _____

Address: _____ Zip Code: _____

TO THE PHYSICIAN: As delineated in the **Special Programs and Procedures for Exceptional Students** document, Miami-Dade County Public Schools requires a referral from a physician licensed in the state of Florida before the district can assess a student to determine the need for educationally relevant physical therapy in the public schools. The Individuals with Disabilities Education Act (IDEA) refers to educationally relevant therapy as therapy needed by a student to access the educational program. It does not address medical or rehabilitation needs.

If you have any questions about this form, please contact the Supervisor of Physical and Occupational Therapy Programs at (305) 995-1266.

DIAGNOSIS

PRIMARY PHYSICAL DISABILITY

PRECAUTIONS: Physical Therapy sessions are active and dynamic (involve multiple positions & movements). Please include positions/activities/movements to avoid:

I certify that I am one of the physicians caring for this patient. I recommend an assessment and approve the provision of physical therapy services if deemed necessary for his/her educational needs.

Physician's Name (*print*) _____ (*signature*) _____ Date _____

Address _____ Telephone _____

To the Parent or Guardian: Please return this form to your child's school.