Clear Form

REQUEST FOR REVIEW OF MEDICAL DOCUMENTATION FOR SPECIAL TRANSPORTATION AND/OR MEDICAL CONSULTATION

This form should NOT be used when requesting Nursing or Respiratory Therapy Services

TO: District Medical Consultant Liaison, MC: 9953, Attn: PT/OT, Fax: 305-270-8033

FROM: _____ _____ _____
Name/Staffing Specialist **SPED Center/MC** **SPED Supervisor**

_____ _____ _____
Phone Number **Fax Number** **Date**

REQUEST FOR: ☐ Specialized Transportation* REQUEST FOR: ☐ Medical Consultation*

Student _____ ID _____ School _____ Exceptionality _____

DOCUMENTS ATTACHED: ☐ FM-1920, Physician's Statement ☐ Current IEP ☐ Section 504 Plan
☐ Consent for Mutual Exchange of Information ☐ Other _____

*** Specify your request/questions for the Medical Consultant:**

_____

_____

Reviewed by District Liaison _____ Date _____

Date Sent to Medical Consultant _____

Medical Consultant Recommendations:

☐ **Recommended** ☐ **Permanent Disability** ☐ **Needs Annual Review**

☐ **Not Recommended**

☐ **Needs Additional Information** _____

SPED Center contacted for more information via:

Phone _____ Email _____
Fax _____ Returned _____

_____ Date _____
Signature of District Medical Consultant/University of Miami
Medical Case Review/Recommendation(s) attached

(Please forward your recommendations to the SPED Center Supervisor and the District Liaison)

xc: Administrative Director, Office of Special Education and Educational Services
District Director, Division of Special Education
SPED Instructional Supervisor, SPED Center
Principal _____