DIVISION OF SPECIAL EDUCATION

DOC TYPE 2515

PHYSICIAN'S REFERRAL FOR PHYSICAL THERAPY ASSESSMENT

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

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

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PRIMARY PHYSICAL DISABILITY

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

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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.

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