Clear Form

EXCEPTIONAL STUDENT EDUCATION
PHYSICIAN'S REFERRAL FOR CHANGE IN HEALTH STATUS FOR PHYSICAL AND OCCUPATIONAL THERAPY

(Post-Surgery, Hospitalization, Serious or Prolonged Illness, Placement in HHIP, or injury)

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: In the event of a surgery, Physical/Occupational Therapy services cannot be resumed until this form is completed by the physician who performed the child's surgery and returned to the school therapist. It is necessary for the school therapist to know the nature of the surgery and the precautions to be observed during the post-surgical therapy. If you have any questions about this form, please contact the Supervisor of Physical and Occupational Therapy Programs at (305)995-1266.

DIAGNOSIS:_____
_____

CONDITIONS REQUIRING SURGERY/HOSPITALIZATION/PROLONGED ABSENCE:_____
_____
_____

SURGICAL PROCEDURE(S) PERFORMED:_____
_____
_____

PRECAUTIONS: Both PT and OT sessions are active and dynamic (involve multiple positions & movements). Please include positions/activities to avoid._____
_____
_____

☐ I certify that I am the physician who performed the surgical procedure(s) on this patient. I approve the provision of physical/occupational therapy services if deemed necessary for his/her educational needs.

☐ I certify that I am the physician caring for this patient related to the injury or illness. I approve the provision of physical /occupational 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.