



Intermediate School District 917

Dakota County Low Incidence Special Education Programs

Director of Special Education: Melissa Schaller

PHYSICIAN REFERRAL FOR PHYSICAL THERAPY SERVICES & PARENT CONSENT-TO-RELEASE-INFORMATION FORM

For Parents:

Parents give permission for the school physical therapist and designated professionals listed below to exchange school and medical information for one year from the date.

Primary Care Physician	_____	Phone #	_____
Orthopedic Physician	_____	Phone #	_____
Neurologist	_____	Phone #	_____
Orthotist	_____	Phone #	_____
Private Physical Therapist	_____	Phone #	_____
Other	_____	Phone #	_____

Parent/Guardian Signature

Date

Dear Doctor:

Physical therapy services are offered by the District 917 Physical Therapy Program as a special education service provided the services are necessary to meet the educational goals of the child. Physical therapy services performed in the school are based on an educational rather than a medical model.

In order to provide service we will need your current referral. This information, along with our evaluation and records, will determine how the child's physical disability limits his/her functioning in the educational environment. If appropriate, the student will be provided with physical therapy in the school setting. Thank you for your assistance.

THE INFORMATION BELOW MUST BE COMPLETED IN FULL AND SIGNED BY THE CHILD'S PHYSICIAN IN ORDER FOR DISTRICT 917 TO INITIATE AND/OR CONTINUE WITH THERAPY. PLEASE RETURN THIS FORM BY FAX TO THE DISTRICT 917 OFFICE—952-707-3096.

Child's Name: _____ Child's Birth Date: _____

Address: _____

Medical Diagnosis: _____

Precautions or Restrictions: _____

Pertinent Medical History: _____

Please indicate what educational implications could arise if no physical therapy services are provided by the educational program: _____

Physician Signature

Date

Physician's Name, Address and Phone
(or use office stamp)

