OCCUPATIONAL THERAPY ● PHYSICAL THERAPY ● ASSISTIVE TECHNOLOGY

ORIENTATION & MOBILITY ● PERSONAL CARE ● SPEECH THERAPY

Physician's Referral

Date: _____

Student Name: _____ **Student D.O.B.:** _____

Attending District: _____ **Therapist/s:** _____

With your approval, we would like to provide the following service/s to assist this student:

☐ Occupational Therapy ☐ Physical Therapy ☐ Assistive Technology Services

☐ Orientation & Mobility Instruction ☐ Speech Therapy ☐ Personal Care

Occupational Therapy: Evaluation and/or treatment in order to improve visual motor, sensorimotor, fine motor and gross motor skills as well as to promote neuromuscular development. Additionally, treatment may be utilized to improve functional performance and independence with activities of daily living which may include feeding/oral motor training and/or assistive technology device coordination and training.

Physical Therapy: Improvement in fine and gross motor skills; gait, strength and mobility training; pulmonary enhancement; and assistive technology device coordination and training.

Orientation & Mobility: Development/improvement in body concepts, gross motor skills, orientation and travel skills in a variety of familiar and unfamiliar areas including use of adapted devices as needed for safe travel.

Speech Therapy: Based on a completion of formal and informal assessments and monitoring of progress in conjunction with recommendations made by members of the IEP Team, this student has speech and language deficits that interfere with academic progress in the general curriculum. Speech and language services are be delivered that reflect the individual needs within the deficit areas.

Personal Care Referral: Services to assist student may be provided and may include one or more of the following: Eating/Feeding; Respiratory Assistance; Toileting; Ambulation; Grooming; Dressing; Transferring; Personal Hygiene; Meal Preparation; Skin Care; Bathing; Mobility/Positioning; Continence Training; Assistance with self – administered medication; Redirection and intervention for behavioral skills; Health related functions through hands – on assistance, supervision and cuing.

This prescription will be in effect from: _____ through _____.

PHYSICIAN'S USE ONLY

Physician's Signature: _____ **Date:** _____

(Note: Medicaid will not accept a **stamped** physician signature)

Printed Physician's Name: _____ **Phone Number:** _____

Physician's Address: _____

_____

Send to: Cheboygan-Otsego-Presque Isle Educational Service District
Special Education Department
6065 Learning Lane
Indian River MI 49749