Chicago Public Schools

ODLSS Office of DIVERSE LEARNER SUPPORTS + SERVICES

Referring School: _____
School phone number: _____
School fax number: _____

Physician's Referral for Occupational and/or Physical Therapy

Child's Name: _____ Date of Birth: _____

Home Address: _____ Telephone: _____

Student ID #: _____ Grade: _____ School: _____

(To be completed by physician, a delegated physician assistant or an advanced practice nurse collaborating with a physician.)

Medical Diagnosis/History (seizures, etc): _____ **ICD-10 Code** _____

Precautions & Contraindications: _____

Recent surgeries or changes in condition (please include weight bearing status): _____

Current Medications/Dosage/Frequency: _____

Wheelchair/Equipment Needs: _____

Check if current problem: ____vision ____hearing _____swallowing ____Incontinence

Is student toilet trained?	__YES	__NO			
Can student negotiate stairs:	__YES	__NO	Comments:		
Regular physical education:	__YES	__NO	**If no**, modified physical education:	__YES	__NO

COMPLETE ONLY RELEVANT SECTION(S)

(To be completed by physician, a delegated physician assistant or an advanced practice nurse collaborating with a physician.)

Occupational Therapy Recommendations

Evaluate and Treat as appropriate for **school-based goals.**
Comments:

_____
National Provider Identifier (NPI)

_____
IL Medicaid Provider Number

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

Physician's Name: _____ **Phone:** _____
(print)

Address:
Hospital Affiliation:

(To be completed by physician, a delegated physician assistant or an advanced practice nurse collaborating with a physician.)

Physical Therapy Recommendations

Evaluate and Treat as appropriate for **school-based goals.**
Comments:

_____
National Provider Identifier (NPI)

_____
IL Medicaid Provider Number

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

Physician's Name: _____ **Phone:** _____
(print)

Address:
Hospital Affiliation: