Hamilton-Boone-Madison Special Services Cooperative
Hamilton-Boone-Madison Education Center
1775 Field Dr., Noblesville, IN 46060
Phone: 317-773-2134
Fax: 317-773-2136

Dear Parents:

Your child has been referred for a physical therapy evaluation of gross motor skills. After receiving the signed physician (for physical therapy only) and parent referral, the therapist will have fifty (50) school days to complete the evaluation and case conference. During the evaluation, your child's skills within the school environment will be evaluated. Following the evaluation, a case conference will be held to discuss the results of the testing with you.

Federal law mandates that physical therapy in schools be educationally relevant. With this in mind, delivery of therapy services in the educational setting is distinctly different from clinically based, medically necessitated treatment. Within the educational environment, PT can be provided to those students whose disability affects their educational performance. Although medical conditions and/or a disability may be present, unless it affects the student's ability to benefit from the individualized educational program, therapy services may not be required.

The determination of the level of services is a joint effort between parents, teachers, and therapists. The need for therapy should be driven by the educational need and the educational relevance of therapy services. Therapy services must be documented within the IEP.

If therapy is indicated, it may be provided through direct services or support to staff and your child. It may be provided in an integrated, naturally occurring, or pull-out setting, and may be with a small group or individually with your child. Therapy services may involve staff professional development and training. The level of services should reflect the student's level of independence within his/her academic setting.

The teachers and therapists look forward to meeting with you to discuss the results of the evaluation.

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______Eval.
______Renewal
______Support

Dear Parent:

Enclosed, you will find a **PARENT/PHYSICIAN REFERRAL** form for the 2015-2016 school year.

Please fill out the upper portion and sign **PARENT PERMISSION.** Take this form to your physician for the lower portion to be filled out. Return the **COMPLETED FORM** to the attention of Joan Kriehn by:

1. Fax – (317)773-2136
2. Email – joan_kriehn@nobl.k12.in.us
3. Postal Mail - HAMILTON-BOONE-MADISON
   Special Services Cooperative
   1775 Field Dr.
   Noblesville, IN 46060

This form/signature is good for one calendar year. It is imperative that we have this completed form in our files within one calendar year from the date of the physician's signature on the previous form for your child to continue to receive physical therapy services at school. This form/signature is required for any student with physical therapy in their IEP, including those on support services. If you have any further questions, please feel free to call me at 773-2134.

Thank you.

Sincerely,

Dr. Steven A. Wornhoff, Ph. D.
Director of Special Services

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MEDICAL REFERRAL FOR PHYSICAL THERAPY

Student's Name: DOB:
Parent/Guardian:
Address:
Home Phone: Work Phone:
Resident Corporation: School Attending:
Reason For Referral:

For the purpose of providing the most appropriate instruction and assistance in my child's educational program, permission is given to conduct a Physical Therapy evaluation and provide intervention as determined by the case conference committee.

Parent/Guardian signature:____ Date:___________

I consent for the release of information to and from the following physicians, hospitals, clinics, therapists:____

Names of physicians, hospitals, clinics, therapists, or other service provider

Parent/Guardian signature:____ Date:___________

PHYSICIAN AUTHORIZATION

Diagnosis: ____

Medications: ____

Contraindications/Special Precautions: ____

Authorization is given to conduct a Physical Therapy evaluation and provide intervention as determined by the case conference committee to enable a student with a disability to benefit from his/her educational program.

Physician signature:____ Date:_____________

____
Physician's printed name, address, and telephone number

AUTHORIZATION IS VALID FOR ONE YEAR FROM DATE OF PHYSICIAN'S SIGNATURE

Please return completed form to the Cooperative:

Fax – (317) 773-2136 Email – joan_kriehn@nobl.k12.in.us or
USPS mail to: 1775 Field Dr, Noblesville, IN 46060