

REQUEST FOR OCCUPATIONAL AND PHYSICAL THERAPY SERVICES

Request is for the _____ School Year

Request is for the _____ ESY

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OCCUPATIONAL THERAPY EVALUATION

INDICATE CSE

Date & Time if Known:

- Consent to evaluate form
- Current psychological report
- Current neurological and/or developmental reports
- Health appraisal
- Indicate physician's name

INITIAL

RE-EVALUATION

IEE

*For 1st Year Student in
BOCES Program*

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OCCUPATIONAL THERAPY DIRECT SERVICES

Individual

Frequency (number of sessions per month)
Duration (minutes per session)
Location

Group

Frequency (number of sessions per month)
Duration (minutes per session)
Location
Ratio

☐

OT CONSULTATION SERVICES

Frequency (number of hours per year)

INDICATE CSE

Date & Time if Known:

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PHYSICAL THERAPY EVALUATION

- Consent to evaluate form
- Current neurological report
- Current orthopedist report
- Health appraisal
- Indicate physician's name

INITIAL

RE-EVALUATION

IEE

*For 1st Year Student in
BOCES Program*

☐

PHYSICAL THERAPY DIRECT SERVICES

Individual

Frequency (number of sessions per month)
Duration (minutes per session)
Location

Group

Frequency (number of sessions per month)
Duration (minutes per session)
Location
Ratio

☐

PT CONSULTATION SERVICES

Frequency (number of hours per year)

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PHYSICAL "Aquatic" THERAPY SWIM

Frequency (number of sessions per week)
Duration (minutes per session)

To assist BOCES in fulfilling your request, please indicate:

Reason for Request or any additional information: