

Date Referral Received: _____

**JORDAN SCHOOL DISTRICT
PHYSICAL THERAPY REFERRAL FORM**

Although certain disabling conditions can cause motor dysfunction, students receive physical therapy (PT) through the school system **only if the condition adversely affects their educational performance**. The PT assigned to your school is **available for consult prior to making a formal referral** for a student.

The following situations may indicate the need for a PT referral:

- The student’s disability interferes with his/her ability to function adequately within an educational setting.
- The student’s current level of motor achievement is not consistent with other areas of development.
- Modifications to the school environment have not been made or are not effective.
- The student has not learned appropriate strategies to compensate for deficits.

BEFORE RETURNING, PLEASE COMPLETE THE ENTIRE REFERRAL FORM

Student name: _____	Date of Referral: _____
Date of Birth: _____	School: _____
Diagnosis: _____	Regular Ed Teacher: _____
Medications: _____	Special Ed Teacher: _____
Vision: _____ Glasses Y / N	Grade: _____ Track: _____
Hearing: _____	
Assistive Device? Wheelchair Walker Leg/Ankle braces	

Person requesting referral: _____

Person submitting referral: _____

Is parental consent to evaluate current? YES / NO Date of parent signature: _____

Please attach a copy of parental consent

Reason for referral and Areas of Concern may include, but are not limited to: floor mobility, standing, walking, wheelchair mobility, seating, access to school, bathroom needs, and physical barriers in school.

If PT services are warranted, a student may be served through consultation or direct services. Therefore, interventions may range from handouts, classroom strategies, or in-service training to a one-on-one or small group setting in order to help students develop skills for the classroom and school. Additionally, when therapy no longer affects a change in the student’s level of function or rate of skill acquisition, direct services will be modified and/or discontinued.

STATUS OF PHYSICAL THERAPY REFERRAL: (TO BE COMPLETED BY Physical Therapist)

- Physical therapy evaluation is: in progress/completed**
- Reason referral does not warrant PT assessment at this time**

Comments: _____

Signature of PT

Date

Please complete the following questionnaire and return it to the **Motor Development Team/Physical Therapists** at the **Auxiliary Services Building**. If the parent/guardian has initiated this referral, please have them fill out this form in addition to the one being completed by the student's school team.

Please circle the area(s) of concern and give a brief explanation.

The student requires PHYSICAL ASSISTANCE for the following:

GROSS MOTOR ACTIVITIES	EXPLANATION
Floor Mobility - PRESCHOOL ONLY Rolling Crawling Transitions in/out of floor sitting	
Sitting balance Floor Classroom Chair	
Standing balance With support (at a table or hand-held support) Without support	
Transitions Getting on/off classroom chair Getting up/down from the floor	
Walking (with or without walking aid) Crowded/uncrowded hallway Classroom/school distances Even/uneven surfaces Stairs with/without a railing Curbs	
Wheelchair Mobility Manual wheelchair Power wheelchair	
Building Access Opening/Closing school doors Moving through doorways	
Bathroom Access Transferring on/off toilet Exterior/stall doors Faucets/soap/paper towels	
Playground Access	
Other	