HEALTHY CPS
OFFICE OF STUDENT HEALTH & WELLNESS

Referring School:_____
School Phone Number:_____
School Fax Number:_____

PROVIDER'S REFERRAL FOR OCCUPATIONAL AND/OR PHYSICAL THERAPY

Student's Name:_____ Date of Birth:_____
Home Address: _____ Telephone:_____
Student ID #:_____ School:_____

To Be Completed by a Licensed Medical Provider (MD, DO, APRN, PA)

Medical Diagnosis/History:_____ ICD-10 Code:_____
Precautions & Contraindications:_____
Recent surgeries or change in condition (please include weight bearing status):_____
_____
Current Medications/Dosage/Frequency:_____
Wheelchair/Equipment Needs:_____
Check if current problem: ____Vision ____Hearing ____Swallowing ____Incontinence

	Yes	No	
Is student toilet trained?	____	____	
Can student negotiate stairs?	____	____	Comments:
Regular physical education	____	____	If no, modified PE? ____Yes ____No

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COMPLETE ONLY RELEVANT SECTIONS (must be completed by a licensed medical provider)

Occupational Therapy Recommendations: Evaluate and treat as appropriate for **school-based goals.**

Comments:

_____

Provider Name	Provider Signature	NPI #	IL Medicaid Provider #

_____

Address	Hospital Affiliation	Phone #	Date

Physical Therapy Recommendations: Evaluate and treat as appropriate for **school-based goals.**

Comments:

_____

Provider Name	Provider Signature	NPI #	IL Medicaid Provider #

_____

Address	Hospital Affiliation	Phone #	Date