Region 14 - Hopewell Center
Consultation/Evaluation Referral Packet
For Children 3 to 22 Years Old
(Revised for 2011-2012 school year)

Please use this packet to request the following Hopewell services:

- Motor Evaluation (Adapted Physical Education, Occupational Therapy, Physical Therapy)

Please:

1. **Provide the information listed,**
2. **Provide the child's name and social security number below,**
3. **Please indicate if student has been identified with a disability,**
4. **Please indicate if student is on an IEP or 504, if so please attach,**
5. **Sign below,**
6. **Send this page along with all information listed for the Motor Evaluation (Adapted Physical Education, Occupational Therapy, Physical Therapy) you are requesting.**
7. **Send to Region 14 - Hopewell Center attention Diane Mason.**

Thank You!

I am requesting Region 14 - Hopewell Center provide the service(s) indicated below for;

______________________________ ______________________________

Child's Name Child's Social Security Number

Motor Evaluation

- **Copy** of Referral for Evaluation (Form PR-04) if this is an initial evaluation.
- Permission to Consult – **Enclosed**
- Motor Evaluation Information (Preschool or School-Age)
- Copy of Physical Therapy Prescription from Physician if P. T. is requested.

Please indicate if student is P/S or School Age, type of referral & due date:

_____ ***Preschool*** _____ ***School Age***

- ☐ **Transition Meeting** **due date** __________
- ☐ **Initial Evaluation** **due date** __________
- ☐ **Re-evaluation** **due date** __________

Has student been identified with a disability? _____ **Yes** _____ **No**

Is student on an IEP? _____ **Yes** _____ **No**

Is student on a 504 ? _____ **Yes** _____ **No**

______________________________ ______________________________ ____________

District Contact Person Signature District Date

PR-04 REFERRAL FOR EVALUATION

CHILD'S INFORMATION

NAME: ______________________ ID NUMBER: ______________

STREET: ______________________ GENDER: __________ GRADE: ____

CITY: ______________________ STATE: OH ZIP: __________

DATE OF BIRTH: ______________

BUILDING OF CURRENT ATTENDANCE: ______________________

TEACHER(S): ______________________

STUDENT'S NATIVE LANGUAGE (if not English): ______________________

PARENT'S NATIVE LANGUAGE (if not English): ______________________

PARENTS' / GUARDIAN INFORMATION

NAME: ______________________

STREET: ______________________

CITY: ______________________ STATE: OH ZIP: __________

HOME PHONE: ______________ WORK PHONE: ______________

CELL PHONE: ______________ EMAIL: ______________

Reason for Referral:

[ ]

EDUCATIONAL HISTORY

Provide data about the child's progress in the general curriculum or, for the preschool-age child, data pertaining to the child's growth and development:

[ ]

Provide data from previous interventions, including Interventions required by rule 3301-35-06 or; for the preschool child, data from early intervention, community or preschool providers:

[ ]

Provide any relevant trend data beyond the past twelve months, including the review of current and previous IEPs:

[ ]

Number of school districts attended: _____

Years at present school building: __________

List schools/early childhood programs and dates:

[ ]

ATTENDANCE:

☐ Regular ☐ Irregular

Is this student age-appropriate for grade level? ☐ Yes ☐ No

BACKGROUND INFORMATION

A. Health Data

Do you suspect problems with ☐ Vision ☐ Hearing

Does the student ☐ Wear Glasses ☐ Use hearing aid(s)

PR-04 REFERRAL FOR EVALUATION

Does the student take medication ☐ Yes ☐ No

Does the student have any health/developmental/physical problems of which you are aware? ☐ Yes ☐ No

B. Environmental Factors

Describe any specific home factors that might affect the student's performance in school

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For Preschool Children Only *(please check the area(s) of concern):*

☐ Eating
☐ Receptive Communication
☐ Cognitive
☐ Vision
☐ Other
☐ Dressing
☐ Expressive Communication
☐ Fine Motor
☐ Social/Emotional Behavior
☐ Toileting
☐ Hearing
☐ Play
☐ Attention
☐ Gross Motor

Describe any other pertinent information not previously described:

SIGNATURES

Signature of Person Initiating the Referral

Position or Relationship to Student

Date

Signature of Person Receiving the Referral

Title

Date Received

Date District Suspects a Disability

Permission to Consult

I, ____, hereby give my permission for the
Parent/Legal Guardian/Surrogate

____ to respond to a request for assistance
School District

for ____.
Name of Child

I am giving my permission for the following assessments (***please check all that apply***):

- ❑ Review of relevant records (releases of information will be included)
- ❑ Interviews with caregiver, myself, teacher
- ❑ Observation(s) of my child
- ❑ Assessment (e.g., curriculum-based, screening, and other appropriate measures to determine interventions)
- ❑ Augmentative/Communication Evaluation (team decision making process for communication technology which includes meetings every 4 – 6 weeks and may include trials of assistive technology and/or picture communication systems.)
- ❑ Permission to evaluate child for physical therapy services.
- ❑ Permission to release physical therapy evaluation to child's physician.
- ❑ Other (please specify): ____

I further understand and agree that the information collected by the school district will then be reviewed and the team will develop an intervention plan and designate the resources needed to implement these interventions.

______________________________	______________________________
Child's Physician	**Name of Parent/Legal Guardian/Surrogate**
______________________________	______________________________
Address, City, State, Zip code	**Signature**
______________________________	______________________________
Phone #	**Date**

Region 14 - Hopewell Motor Evaluation
Pre-school or School Age

Name: ______________________________________ Date of Birth: _____________________

District: __________________________ School: __________________________ Grade: ______

Please check service area(s) for which you are requesting an evaluation. A physical therapy evaluation will require a doctor's prescription *or* permission from parent to forward P.T. evaluation to Doctor (on permission to consult page).

_____ Occupational Therapy

___ Fine Motor skills
___ Sensory/Attention Issues
___ Handwriting
___ Self Care in school setting
___ Feeding/Oral Motor
___ Adaptive Equipment

_____ Physical Therapy

___ Gross Motor Skills
___ Walking/Balance
___ Stair Climbing
___ Positioning in school
___ Wheelchair mobility
___ Wheelchair needs
___ Adaptive Equipment

_____ Adaptive Physical Education

___ Gross Motor Skills of P.E.
___ Modification/Adaptations for P.E.
___ Adaptive Equipment Recommendations

What is your main concern for this student:

____
____
____
____
____

Does the student have a current IEP? _____ Yes _____ No

Is there any other information you would like us to know about the student?

Region 14 – Hopewell Center
5350 West New Market Road Hillsboro, Ohio 45133
Telephone: (937) 393-1904 Fax: (937) 393-0496
ohioregion14.org

DATE: ______________________________

Dear Parents and Physicians:

Physical therapy in public schools is different then physical therapy in a hospital, clinic or home health setting. Whereas the hospital therapist directs her/his attention primarily toward rehabilitating the physical impairments of the child, my focus will be toward removing any barriers that may limit the child's ability to execute functional tasks required in the school environment more proficiently, and teaching appropriate personnel to understand different considerations that must be given to a child with a disability.

I work with the teachers and staff in helping each student acquire the functional abilities needed to access his/her educational environment during the school day. I may work with the student and adapt his equipment so that he/she can function better while at school, whether in the classroom, the lunchroom, or the playground. During the Physical Therapy assessment, I will be evaluating many areas including your child's gross motor skills, balance, and his ability to access his/her environment either by walking and/or wheelchair.

Special education students are in a demanding environment when at school. The methods used in presenting educational materials to them and their mobility in a school environment must be modified to meet the demands of their disability. The child's disorder may complicate the ability to communicate, to view educational materials, to move about the school environment. I will work closely with his/her teachers to promote the highest level of function for the student while he/she pursues his/her educational goals. Any information you can share to assist us in this endeavor is greatly appreciated.

Doctor, Please sign and return the enclosed **PT script** if you wish ____________________________
D.O.B. ________________________ to receive school based services for the 2009 - 2010 school year.
Please include a diagnosis and corresponding ICD-9 code to assist us in best meeting the child's medical needs.

Sincerely,

Ellen Ryan, P.T.	Tracy Ames, P.T.
Physical Therapist	Physical Therapist

Confidential

Medical Authorization for Physical Therapy
Evaluation/Services to meet Educational Need

Date: ______________________

To Whom It May Concern:

____ is in need of
(Child's Name)

Check all that apply:

- **_____ A physical therapy evaluation as a part of the multi-factored evaluation**
- **_____ School based Physical Therapy to meet educational needs**
- **_____ Adaptive Equipment (positioning devices, etc.) ______________________________**

____

____

<u>Diagnosis & ICD-9:</u>

____

____

____

____

____

____
(Name of Physician)

____
(Signature of Physician)

____
(Address)

____
(City) (State) (Zip Code)

____
(Phone Number)

<u>Precautions/Suggestions:</u>

____

____

____

____

____

Dear Parents/Guardians:

We would like to notify you that Region 14 – Hopewell Center has become eligible to receive Medicaid reimbursement for Augmentative Communication, Audiological, Speech Therapy Service, Occupational Therapy Services, Physical Therapy Services and Psychological Assessments. Unless we receive a note of denial or a phone call from you, we will be billing Medicaid for your child.

If you have any questions, please call Diane Mason at Region 14 – Hopewell Center, 937-393-1904 ext. 115.

Thank you.