LUZERNE INTERMEDIATE UNIT 18
Special Education Department
368 Tioga Avenue
Kingston, PA 18704

REFERRAL FOR OCCUPATIONAL / PHYSICAL THERAPY SERVICES

Student:______________________________ Date:______________________________

Teacher:______________________________ Date of Birth:______________________________

District:______________________________ Building:______________________________

Parent/Guardian:______________________________ Present Placement:______________________________

Address:

Diagnosis:____

Suspected Problem Areas:

OT	PT
Fine Motor	Needs Adaptive Seating / Positioning
Activities of Daily Living	Range of Motion, Stretching
Sensory	Poor Mobility
Perceptual	Coordination / Balance
Positioning, Adaptive Equipment	Strength, Endurance
	Gross Motor

Reason for Referral:

How does this problem interfere with the student's educational goals:

Teacher's Signature______________________________ Date____________________

Supervisor's Signature______________________________ Date____________________

Therapist's Signature______________________________ Date____________________