

Plattsburgh City School District  
Occupational and Physical Therapy Referral Form

Evaluation Requested

\_\_\_\_\_ Occupational Therapy                      \_\_\_\_\_ Physical Therapy

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_

School: \_\_\_\_\_ Teacher: \_\_\_\_\_

Parent Name: \_\_\_\_\_

Address \_\_\_\_\_

Phone: \_\_\_\_\_ cell \_\_\_\_\_

Parent contact to discuss referral done by: \_\_\_\_\_

Person Making Referral, location & phone: \_\_\_\_\_

Present Classification(if any) \_\_\_\_\_

List any special services the student presently receives

\_\_\_\_\_  
\_\_\_\_\_

Reason for referral and area of concern \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

List Tier Interventions and Results: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Building Principal (signature)    date

\_\_\_\_\_  
CSE Chairperson (signature)    date