**Sumner County Educational Services Interlocal, District 619**

2612 N. A, Wellington, KS- Phone ~ 620-326-8935 Fax ~ 620-326-6496

**Script for Physical, Occupational, & Speech Therapy Services**

**Date:**

**Dear Dr. Clinic:**

**Phone: Fax:**

## Your patient , DOB , qualifies for educationally based therapy services. The services are provided at no cost to the family as is mandated by federal and state regulations and will take place in the school setting from through .

**Physical Therapy** Treatment Diagnosis: Frequency & Duration:

Therapeutic Exercise

Balance

Posture

Group Therapy

Transfer Skills

Neuromuscular Reeducation

Coordination

Proprioception

Developmental Motor Skills

Mobility Training

Range of Motion

Kinesthetic Sense

Gait Training

Consultative Services to Classroom & Staff

Tone Management

Positioning

Provision of/Instruction in Adaptive Equip. Sensory Processing

## Therapist Signature: Date: Phone Number:

**Occupational Therapy** Treatment Diagnosis: Frequency & Duration:

Therapeutic Activities

Community/Work Integration

Development of Cognitive Skills

Self Care & Home Management

Sensory Integrative Techniques

## Therapist Signature: Date: Phone Number:

**Speech Therapy** Treatment Diagnosis: Frequency & Duration:

Treatment of Speech, language, voice, communication, and/or auditory processing

Treatment of speech, language, voice, communication, and/or auditory processing disorder of a group, 2 or more

## Therapist Signature: Date: Phone Number:

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Please complete this form as soon as possible, via fax 620-326-6496 or U.S. Mail.

*A signed medical records release of information by child’s parent/legal custodian has been included with referral request and is on file with Interlocal 619, which is available upon request.*

*The school district is required to have a signed doctor’s referral/plan of care before a child can begin receiving therapy services, please review plan(s) of care above and complete physician statement below including:* ***Medical Diagnosis,*** *Special Considerations/precautions, Comments****, Physician’s Signature AND Date of Referral.***

*This script will be* ***effective*** *for* ***One Year*** *from date of referral.*

**PHYSICIAN STATEMENT**

***Medical Diagnosis:***

**Comments, Precautions, Special Considerations:**

***Physician Signature: Date:***