Sumner County Educational Services Interlocal, District 619

221 W. 15th, 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
__Positioning
__Neuromuscular Reeducation
__Coordination
__Proprioception
__Developmental Motor Skills
__Mobility Training
__Provision of/Instruction in Adaptive Equip.
__Range of Motion
__Kinesthetic Sense
__Gait Training
__Consultative Services to Classroom & Staff
__Tone Management
__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 District 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:*** _____