INTERMEDIATE UNIT I
FAYETTE-GREENE-WASHINGTON
SPECIAL EDUCATION AND SERVICES
TELEPHONE 724-938-3241
FAX 724-938-8722

Physician's Authorization Form
Occupational/Physical Therapy

This is a referral for: (Please check all that apply)

☐ **Occupational Therapy**

☐ **Physical Therapy**

Child's Name: ______________________________ DOB: __________

Street Address: ______________________________

City, State, Zip: ______________________________

In order for Intermediate Unit #1 to provide Occupational and or Physical Therapy services for the child whose name is listed above, it is important that we have a current diagnosis, a listing of recent or anticipated surgery, and any recommendations which you might offer. We would also appreciate your listing any special precautions that may need to be taken while working with this student.

Diagnosis: ______________________________

Recent or anticipated surgery or physical procedures: ______________________________

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Special precautions: ______________________________

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Recommendations: ______________________________

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Physician's Signature ______________________________ Date ______________

Address ______________________________

____

Phone Number ______________________________

Please Return to School District Contact: ______________________________

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Intermediate Unit I is an Equal Rights and Opportunities Educational Agency