PHYSICIAN'S PRESCRIPTION/REFERRAL FORM

In order for students to receive school based services they must have current documentation of a medically based condition. This condition must interfere with the student's ability to function effectively in his/her educational program. ***Therapy services in schools are based on education relevance and need, and are determined by the Individualized Education Program (IEP), Individualized Family Service Plan (IFSP) or Plan of Care.***

Student: _____ Date of Birth: _____ Date: _____

Attending School District: _____

Educational Diagnosis: _____

Physical Therapist Recommendation

- ☐ Evaluate & Treat per IEP/IFSP or Plan of Care
- ☐ Muscle Strengthening
- ☐ Range of Motion
- ☐ Balance & Coordination
- ☐ Gait Training & Mobility
- ☐ Positioning
- ☐ Other _____

Occupational Therapy

- ☐ Occupational Therapy – This student was evaluated for occupational therapy services. The recommendation is for occupational therapy per the current IEP/IFSP/Plan of Care.

Speech/Language Therapy Referral

- ☐ Speech/Language Therapy – This student was evaluated for speech and/or language therapy services.
- ☐ The recommendation is for speech and/or language therapy per the current IEP/IFSP/Plan of Care.

By my signature, I authorize my child's physician, the local school district and AAESA to share information related to medical needs and the IEP Team determination.

Parent/Guardian Signature: _____

Printed Name: _____

Date: _____

This prescription covers school based therapy for one year. **NOTE: To participate in Medicaid School Based Services, a valid prescription MUST be signed by a physician and include the date prescription was signed. The prescription must also include the physician's name, address, telephone number and NPI number.** ***Stamped signatures are invalid for school based services.***

Physician's Signature:_____ Date:_____

Print Physician's Name: _____Physician NPI#:_____

Address:_____

Phone: _____Fax:_____

Medicaid Provider ☐ Yes ☐ No

Please fax signed form to AAESA at 269.512.7701, Attn: Angie Lesher,
or email to angie.lesher@alleganaesa.org
Due to Medicaid requirements, this document must be signed by a licensed Physician or Physician's Assistant.