THE SCHOOL DISTRICT OF PALM BEACH COUNTY

Physical Therapy Prescription for Evaluation and/or Treatment

A patient of yours (named below as patient/student) has been referred for a physical therapy evaluation. The therapist will present his/her evaluation at an eligibility meeting and the Individual Educational Plan (IEP) team will then decide if physical therapy services are needed to assist the student in achieving functional goals within the education environment. You will be informed of the team's decision.

Complete the section below indicating your permission to evaluate and treat if educationally relevant. Return the completed form to the therapist. Therapist's name and address are provided at the bottom of this form.

NAME OF PHYSICIAN _____ DATE OF REQUEST ___/___/___

ADDRESS _____

NAME OF PATIENT /STUDENT _____ DATE OF BIRTH ___/___/___

ADDRESS _____

SCHOOL _____

THIS AREA TO BE COMPLETED BY PHYSICIAN ONLY

PATIENT/STUDENT DIAGNOSIS

_____

_____

_____

PRECAUTIONS

_____

_____

_____

_____

_____

_____

I give permission for a physical therapy evaluation and treatment as determined by the IEP team.

_____ _____

SIGNATURE OF PHYSICIAN *DATE*

RETURN TO: NAME OF THERAPIST _____

ADDRESS _____

_____

_____

_____

TELEPHONE NUMBER ( ) - FAX ( ) -

FOR SCHOOL USE ONLY

IEP team recommends:

☐ educationally relevant physical therapy services are indicated

☐ educationally relevant physical therapy services are **NOT** indicated