REFERRAL FORM

Regional Direct Service Team
South Central Ohio ESC
522 Glenwood Avenue, New Boston, OH 45662
(740) 354-0270
FAX: (740) 354-0280

Reason(s) For Making This Referral? **(Description of Problem)**_____
_____
_____
_____
_____

Person Making Referral: _____

INDICATE AREAS FOR ASSESSMENT/OBSERVATION/CONSULTATION

Occupational Therapy ___
*Physical Therapy ___
(For OT & PT see NOTE on back of page)

** Vision ___ ***(For vision see NOTE on back of page)***

Audiology ___
For ***Audiology*** indicate below type of assistance requested
__ assessment ___ observation
__ consultation

****

CHILD

Name _____**DOB** _____
Parent/Guardian _____
Address _____
_____
Phone _____

SCHOOL

Building _____ **Grade** _____
Address _____
Phone _____
Teacher _____
Current Special Services_____
MFE DATE: ____ I.E.P. DATE: ____ I.E.P. TYPE: _____
(disability category)

Prior Evaluations (Dates/Results)
Vision _____ Hearing _____
Physical Therapy _____
Occupational Therapy _____
Psychological _____

Speech/ Language_____
Medical _____ Prosthesis _____
Medications _____
Diagnosis_____

_____ _____, _____ _____
District of Residence **District of Residence Supt. Or Designee** **Title** **Date**

(1 Copy of assessment Report(s) will be mailed to Person signing this Referral)

*__RE: PHYSICAL THERAPY__ (Prescription required for physical therapy assessment)
Name of Referring Physician

**__RE: VISION REFERRALS ONLY__(Adhere to guidelines noted on back of this page)

PLEASE RETURN TO:
Ken Smith, Supervisor
Regional Direct Service Team
522 Glenwood Avenue
New Boston, Ohio 45662

****REFERRALS FOR VISION ASSESSMENT:**

Please refer to the definition of children with visual impairments as defined in Operating Standards for Ohio's Schools Serving Children With Disabilities (Rule 3301-51-01 (F) (3) (m).

Situations warranting a referral are:

•Evaluation teams "suspect a handicapping condition" in the area of vision

OR

•Team members seek assistance with I.E.P. goals and objectives for children ***already*** identified as visually impaired.

NOTE:

REFERRALS FOR P.T./O.T. OT and PT are most often related services. Related services are developmental, corrective and other supportive services as are required to assist a child with a disability to benefit from special education.

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□ Initial
□ Reevaluation

PARENT PERMISSION TO CONDUCT ASSESSMENT

_____ __/__/__
(Student's Name) (D.O.B.)

_____, _____, has requested a member/members of the
(Person making referral) (Title)
Regional Direct Team to complete an individual assessment. Information may be used to develop an Individualized Educational Plan (I.E.P) to assist in providing an appropriate educational placement and to provide specific information relevant to your child's education. Specifically, this evaluation is being requested because

_____
_____
_____

The following person/persons will do the assessment:

_____ Occupational Therapist
_____ Physical Therapist.
_____ Visual Specialist
_____ Audiologist

As the parent, or legal guardian, you have certain legal rights under Section 3301-51-08 (Due Process Procedures) of Ohio's Ohio's Operating Standards for Ohio's Schools Serving Children With Disabilities. *Results of this assessment will be strictly confidential and will be available only to authorized personnel.* Moreover, your child's placement will not be changed without your permission. Please complete the blanks below.

___ **YES**, the Regional Direct Service Team may conduct an individual evaluation for my child.

___ **NO**, the Regional Direct Service Team may not conduct an individual evaluation for my child.

RE: HEARING TESTING! I grant permission for follow-up evaluations to monitor hearing thresholds when test results indicate the need OR when a child is being treated by a physician for ear/hearing dysfunctions, diseases or disorder.

→ → →

Parent/Guardian Signature

_____
Relationship to Child

__/__/__
Date

MUST COMPLETE BACK OF THIS PAGE → → →

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RELEASE OF INFORMATION

_____, __/__/__
(Student) (DOB)

In order to obtain information which may relate to this assessment, I hereby grant permission for

_____
(Name, address, and fax number of referring party)

to send or fax all previous assessment, educational and medical records to the Regional Direct Team, Portsmouth, Ohio. Information provided will not be shared without written permission from parent or guardian.

RE: HEARING TESTING!
This release also includes any new medical information following an audiological evaluation and subsequent medical referral. I understand that my permission may also be extended to releasing and receiving information pertaining to my child from my family physician, specialists, or other agencies who may have information relevant to developing an appropriate educational program for my child.

→ → →_____ __/___/__
(Signature of parent or guardian) **(Date)**

Please list other agencies/individuals who may release information about your child to the Regional Direct Service Team. The referral form is **INCOMPLETE WITHOUT THE FOLLOWING IMPORTANT INFORMATION.**

1. **Family Physician:**_____
   Address: _____
2. **Physician for Physical Therapy Prescription:** _____
   _____
3. **Optometrist or Ophthalmologist (Eye):** _____
   _____
4. **Other Agency or Specialist:**_____
   Address: _____